

The Medical Advisory Group
Meeting Minutes 29th November 2012, 10.00am
PHECC Office, Naas, Co. Kildare

Present

Zelie Gaffney (Chair)
Niamh Collins
Macartan Hughes
Sean Walsh
Gerry Kerr
Martin O'Reilly
Gerry Bury
Declan Lonergan
Mark Doyle
David Menzies
Cathal O'Donnell
Lawrence Kenna
Brendan Whelan

In Attendance

Geoff King (Director)
Brian Power
Anne Keogh

Apologies

Frank O'Malley
Paul Lambert
David Janes
Valerie Small
Stephen Cusack
Conor Egleston
Peter O'Connor
David McManus
Seamus Clarke
John O'Donnell
Michael Garry
Tom Mooney
Paul Meehan
Sean O'Rourke

Chair's business

The Chair welcomed the assembled members to the meeting and acknowledged apologies from absent members.

2. Minutes

Mark Doyle requested a number of changes to section 3, KPI update of the minutes;

The second sentence should read:- "HIQA had initially stated 8 headings with a number of items under the eight.

The third sentence should read: - "The group plan to circulate a 3 stage Delphi process by e-mail"

The fifth sentence from the bottom should read:- "Mark Doyle stated that HIQA were happy with the process and they see their role as monitoring not dictating".

Niamh Collins requested that in 4.3.4 that 'asthma care programme' be changed to 'COPD care programme'

Resolution: That the minutes from the Medical Advisory Group meeting held on the 25th October 2012 be agreed subject to the changes outlined above.

Proposed: Niamh Collins

Seconded: Mark Doyle

Carried without dissent

3. CPGs

3.1 An email from Adrian Murphy in relation to Paediatric Pain Management was presented in the papers. This e-mail was discussed and it was agreed that a change be made on the pain ladder from “MINOR” pain to “MILD” pain.

Resolution: That the Medical Advisory Group recommends to Council to change the wording from “MINOR” pain to “MILD” pain on the pain ladder of all relevant CPGs.

Proposed: Sean O'Rourke

Seconded: Macartan Hughes

Carried without dissent

3.2 Treat & Refer

Advice received from the Diabetes Programme on Treat & Referral was presented in the papers and discussed. The Diabetes Programme requested that the measurement of blood ketones in the ambulance for patients with blood glucose > 20 mmol/L be completed. This was discussed and a decision was made that it would not be possible in the present circumstances.

The recommendations from the Diabetes Programme in relation to CPG 5/6.9.2 Hypoglycaemia – Treat & Referral were discussed.

The following were agreed for the exclusion criteria after discussion;

- Retain ‘< 30 days since last episode’
- Retain ‘On oral hypoglycaemics’ and add ‘(Sulphonylurea tablets in particular)’
- Add ‘Seizures associated with hypoglycaemia’
- Do not add ‘Remain drowsy or confused post correction of hypoglycaemia’ as this was covered in CPG 5/6.9.1 Clinical Care Pathway Decision – Treat & Referral.
- Add ‘Insulin or oral hypoglycaemics overdose’

It was also agreed to replace ‘Ensure that patient takes in calories’ with ‘Ensure patient takes in both quick (lucozade, fruit juice or sweets) and longer acting carbohydrates (bread, toast, biscuit)’

A discussion ensued on the need for 'Glucagon administered' as an exclusion criteria. Brian Power to follow up with the Diabetes Programme for advice on the matter.

Sean Walsh again stated his concern about treat & referral following IV glucose treatment. Brian Power presented a meta-analysis of the relevant papers on treat & referral outlining that the majority of patients in the studies were treated with IV glucose and not transported. The broad trend of the discussion followed in favour of treat & referral following IV glucose treatment subject to the strict inclusion and exclusion criteria outlined in the CPGs.

A discussion ensued on the need for a call back to the patient after 4 hours to ensure that he/she was ok.

Following discussion, CPG 5/6.9.1 Clinical Care Pathway Decision – Treat & Referral to be amended as follows;

- Replace 'patient / cares' with 'patient and carer'
- Add box 'If medical practitioner is present follow direction on transport decision'

Brian Power explained that due to the nervousness of the introduction of treat & referral that all treat & referral CPGs would be withdrawn except CPG 5/6.9.1 Clinical Care Pathway Decision – Treat & Referral, CPG 5/6.9.2 Hypoglycaemia – Treat & Referral and CPG 5/6.9.3 Isolated Seizure – Treat & Referral. These CPG would form part of the study on treat & referral to inform MAG on the safety of the introduction of treat & referral nationally. He further explained that the sample size calculated for the survey was 862 patients to give a power of 80%, which will take approximately 2 years to recruit. It was identified that GPs in the study areas would have to be informed of its introduction.

3.3 Review of CPGs

3.3.1 CPG 5/6.6.6 Head Injury – Adult

The following changes were agreed;

- Replace 'Loc History' with 'Consider Spinal injury'. Remove reference to collar and long board and direct to spinal injury CPG as appropriate.
- Replace 'GCS < 12' with 'GCS ≤ 12'
- Replace '10° upward head tilt' with 'Minimise increases in intracranial pressure'. Insert supporting text box with 'Pain, Nausea & Vomiting, 10° upward head tilt, Collar too tight'
- Replace 'Maintain SBP > 120 mmHg' with 'Avoid hypotension'
- Delete 'Transport to most appropriate ED according to local protocol'

3.3.2 CPG 4.6.6 Head Injury – Adult

- Add 'V' on AVPU for request of ALS
- Replace 'Apply cervical collar' and 'Secure to long board' with 'Immobilise spine appropriately'
- Insert 'Mechanism of injury – spinal immobilisation indicated'

Resolution: That the Medical Advisory Group recommends to Council the changes to CPG 5/6.6.6 Head Injury – Adult and CPG 4.6.6 Head Injury – Adult as outlined above.

Proposed: David Menzies
Carried without dissent

Seconded: Macartan Hughes

3.3.3 CPG 4.6.2 Shock from Blood Loss – Adult

The following changes were agreed;

- Replace 'ALoC' with 'V, P or U'
- Present signs of poor perfusion in an ABC context.

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 4.6.2 Shock from Blood Loss as agreed.

Proposed: Niamh Collins
Carried without dissent

Seconded: Brendan Whelan

3.3.4 CPG 5/6.2.5 Secondary Survey Trauma – Adult

The following changes were agreed;

- Insert 'Monitor ECG and SpO₂'.
- Insert 'Consider repeat Primary Survey'.

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 5/6.2.5 Secondary Survey Trauma – Adult as agreed.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Gerry Bury

3.3.5 CPG 4/5/6.8.1 Major Emergency (Major Incident) – First Practitioners on site

The following changes were agreed;

- Insert 'on site co-ordination centre' and 'ambulance loading point' in box Practitioner 2.

3.3.6 CPG 4/5/6.8.2 Major Emergency (Major Incident) – Operational Control

The following changes were agreed;

- Insert new text box 'Controller of Operations may be other than ambulance or fire officers, depending on nature of emergency'.

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 4/5/6.8.1 Major Emergency (Major Incident) – First Practitioners on site and CPG 4/5/6.8.2 Major Emergency (Major Incident) – Operational Control as agreed.

Proposed: Declan Lonergan

Seconded: Macartan Hughes

Carried without dissent

3.3.6 CPG 5/6.5.3 Haemorrhage in Pregnancy – Prior to delivery

- The CPG to be renamed to 'PV Haemorrhage in Pregnancy'
- Insert 'Monitor ECG and SpO₂'
- This CPG may require re-design and the meeting recommended that Dr Michael Turner, clinical lead, Obstetrics Programme be contacted for advice on re-design.

3.3.7 CPG 5/6.5.4 Postpartum Haemorrhage

- This CPG may require re-design and the meeting recommended that Dr Michael Turner, clinical lead, Obstetrics Programme be contacted for advice on re-design.

3.3.8 CPG 6.4.23 Poison – Adult

- It was agreed to split the CPG into separate CPGs by poison type, rare poisons and common poisons. Alcohol and Psychostimulant to be given separate CPG.

3.3.9 CPG 5/4.4.23 Poison – Adult

- This CPG to be reviewed in conjunction with the new poison CPGs as outlined above.

3.3.10 CPG 4/5/6.4.17 Symptomatic Bradycardia – Adult

The following changes were agreed;

- Add text box 'Titrate Atropine to effect – HR > 60'

- Add 'NaCl infusion – 250 mL (repeat by one)'

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 4/5/6.4.17 Symptomatic Bradycardia – Adult as agreed.

Proposed: Gerry Bury

Seconded: Niamh Collins

Carried without dissent

3.4 New CPGs

3.4.1 CPG 4/5/6.4.32 Heat Related Illness & Pyrexia – Adult

This CPG was presented for first view by MAG. The following suggestions were made

- Separate the heat related illness and pyrexia into two CPG
- Remove any reference to uncontrolled shivering

3.4.2 CPG 4/5/6.7.18 Heat Related Illness & Pyrexia – Paediatric

This CPG was presented for first view by MAG. The following suggestions were made

- Separate the heat related illness and pyrexia into two CPG
- Remove any reference to uncontrolled shivering

3.4.3 CPG 1.2.3 Opioid Overdose

This CPG was presented for first view by MAG. Gerry Bury outlined the rationale for this CPG which was tabled at MAG. Opioid overdose is occurring in drug treatment centres and this CPG would enable care staff to administer Naloxone to a patient in respiratory arrest. No changes were recommended to the presented CPG. This CPG will go through the Delphi process for further review.

4. Queries re CPGs and medications

4.1 Amiodarone administration following ROSC with VTachy

This issue was presented in the MAG papers by Cathal O'Donnell. He outlined how APs administered Amiodarone infusion to ROSC patients with unstable tachyarrhythmias resulting in very positive outcomes. Because this procedure had been removed from the CPGs the HSE had no choice but to treat these incidents as adverse clinical events. He recommended that MAG reinstate this procedure as it was beneficial for patients. Brian Power was requested to draw up a procedure on the administration of Amiodarone following ROSC.

4.2 Kaltostat for Epistaxis in pre hospital care

Miriam Curran AP, Killybegs, presented in the MAG papers a rationale for the use of Kaltostat for epistaxis where the bleeding could not be controlled using standard methods. The benefits of using a proprietary nasal pack were discussed. Comparisons were made with other products such as Merocel, however it was decided to leave the brand selection to the pre-hospital emergency care service provider. It was agreed that a proprietary nasal pack would be included on the Epistaxis CPG at Paramedic level and above.

Resolution: That the Medical Advisory Group recommends to Council the insertion of the use of a proprietary nasal pack on CPG 4/5/6.4.25 Epistaxis for paramedic and advanced paramedic level.

Proposed: Cathal O'Donnell

Seconded: Niamh Collins

Carried without dissent

4.3 OFA perspective

David Bradley from Medicore Medical Services presented in the meeting papers feedback on OFA level CPGs for review by MAG

4.3.1 CPG 2/3.2.3 Primary Survey – Adult

This CPG was discussed and the following changes were recommended;

- Remove 'Trauma' as the route into the CPG
- Place 'scene safety, scene survey and scene situation' into a single horizontal line
- Remove 'Commence CPR'
- Reverse order of 'Consider expose & examine' and Pulse, Respiration & AVPU assessment'
- Add 'if not already called' to second telephone

Resolution: That the Medical Advisory Group recommends to Council the changes to CPG 2/3.2.3 Primary Survey – Adult as agreed above.

Proposed: Niamh Collins

Seconded: Zelig Gaffney

Carried without dissent

5. KPI – update

Mark Doyle informed the group that there is a panel of approximately 150 selected for the KPI development process.

7. AOB

Cathal O'Donnell asked could an item be added to the next meeting. The HSE NAS are changing to King airway as its choice of supraglottic airway and it will take approximately one year for this change over to be complete. To ensure compatibility across all practitioners within HSE NAS he requested that consideration be given to adding the King airway to the skills matrix for EMTs.

Brian Power suggested for ease of diary management for next year that an agreed day each month be selected for MAG meetings. The meeting agreed that the last Thursday of each month would be selected with the exception of August and December for MAG meetings for 2013.

The Chair thanked the group for their input. The next meeting was scheduled for Thursday 31st January 2013.

The meeting was ended due to time constraints and the remaining items to be included on the agenda for the next meeting.

Signed: _____

Date: _____

The Medical Advisory Group

Meeting Minutes 26th January 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Niamh Collins
Mark Doyle
Lawrence Kenna
Cathal O Donnell
Declan Lonergan
Sean Walsh
Stephen Cusack
Macartan Hughes

Present

Geoff King (Director)
Brian Power
Marion O' Malley
Jacqueline Egan

Apologies

David Menzies
Conor Egleston
Gerald Kerr
Frank O' Malley
John O' Donnell
Sean O' Rourke
David Janes

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. Jacqueline Egan gave a brief presentation on the recent trip to the Isle of Wight (IOW), where a delegation representing Council and MAG, looked at the implementation of the ePCR and how it has impacted on services.

The islands ambulance service is integrated with the IOW's NHS Primary Care Trust, and provides patients with seamless access to all health services. There are three options for accessing care on the IOW:

- a) Phone 999 service for immediate and life threatening incidents
- b) Phone 111 service if you require medical advice but it is not a life-threatening situation
- c) GP walk-in service or emergency department, both in the hospital 24/7

Each of these care options are supported by the NHS Clinical Care Pathways, which was implemented in 2010. All data is captured on an integrated CAD and ePCR system which includes GPS functionality. The ePCR data is transmitted to the eTriage application system in the ED and the reporting system can generate pre-defined reports in addition to KPI reporting for the IOW Trust and for the Department of Health. Jacqueline Egan informed the group, that for the next MAG meeting, some care pathways would be installed on iPADS and disseminated for review.

While the consensus of the delegation was that the trip was very informative and worthwhile, both the Director and Jacqueline Egan expressed concern over the future of the ePCR in Ireland. Currently there is no clinical audit on data collected and the Director suggested requesting six-monthly reports on patient data from all CPG approved organisations, as a new criterion for CPG approval. Following some

discussion Mark Doyle suggested that a strategy document be produced, encompassing points of concern of PHECC and the NAS, to enlighten a decision on the future of the ePCR. Niamh Collins suggested using the NHS Clinical Pathways in Ireland. The Director stressed that direct involvement from NAS/HSE operational people (frontline, procurement, IT) is paramount in agreeing a specification for a pre-hospital information system. Mark Doyle suggested that the Emergency Medicine Programme take the lead on this and recommended that MAG engage with them on this information discussion. It was agreed to draft a letter and include it on the next Council meeting agenda, for approval, prior to engaging with the Emergency Medicine Programme. The Director confirmed that he would engage with the Director of the National Ambulance Service in parallel.

Included in the tabled papers, was a framework document for a Quality Improvement Strategy being put together by the NAS Quality Improvement Programme, and Mark Doyle, as Chair, requested input from MAG in devising a process for the development of KPI's for statutory ambulance services in Ireland. In discussion the Director suggested that CPG approved organisations could be asked to report against specific KPI's on a six-monthly basis as evidence of audit. Mark Doyle requested that MAG facilitate a one-day KPI workshop, with an end goal of identifying and developing KPI's. It was thought that the scheduled March MAG meeting date could be utilised to facilitate this workshop and some guest speakers were put forward to present at the proposed workshop. Brian Power suggested that the Medical Advisor/Director of all CPG approved organisations be involved in this process however, Cathal O' Donnell suggested that, as only statutory services are doing 999 calls, perhaps other service providers' KPI's will be different. It was agreed that the outcome of any KPI workshop be shared with all CPG approved organisations for further discussion.

2. Minutes and Matters Arising

Cathal O' Donnell requested that his comments relating to the need for a reporting tool at EFR level be included under agenda item No. 5. Macartan Hughes suggested some rewording under agenda item No. 4 as follows: '*A discussion was held on the issue of NASC's stringent requirements during the undergraduate internship*'.

Resolution: That the minutes from the Medical Advisory Group meeting of 22nd November 2011 be approved subject to the amendments agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Cathal O' Donnell

3. CPGs

Limb Injury – Adult

Draft CPG 4/5/6.6.5

This CPG has been approved at P and AP level and Brian Power sought approval of this CPG at EMT level. It was confirmed that this CPG will replace the Limb Fracture CPG.

The following changes were agreed:

- Include a pelvic splinting device on the equipment list

Resolution: That CPG 4/5/6.6.5 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Macartan Hughes

Secondary Survey – Paediatric (≤ 13 years)

Draft CPG 5/6.7.4

The following changes were agreed:

- 'Normal rates' to read 'Normal ranges'
- Add 'where possible' to box 'Children and adolescents should always be examined with a chaperone (usually a parent)'
- The contents of 'Check for normal patterns of' to be included in 'Identify presenting complaint' box
- 'Check vital signs' should read 'Re-check vital signs'
- 'If non accidental injury or child abuse suspected' to read 'If child protection indicators are present'
- Change 'Report findings as per Child Protection Guidelines to ED staff in a confidential manner' to read ' Report findings as per Children First Guidelines to ED staff and line manager in a confidential manner'

It was agreed that this updated CPG be brought back to the February meeting prior to dissemination. It was also agreed to check 'Child Protection' on Primary Survey CPGs.

Resolution: That CPG 5/6/7.4 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Sean Walsh
Carried without dissent

Seconded: Mark Doyle

Patient Restraint

Version 0.3 Draft

A paper detailing behavioural emergencies legal issues was included in the meeting papers, along with an example of a (USA) draft policy and procedure regarding the restraint of patients in the out-of-hospital setting. Brian Power suggested that this policy and procedure be used as a guideline in framing a pre-hospital policy on patient restraint. Some discussion took place around this CPG and the general consensus was that the CPG be revised, with a view to amalgamating 3 patient categories and finding the common pathways between them:

- a) Mental Health Emergency
- b) Aggressive/violent patient with alcohol and/or drug intoxication
- c) Aggressive/violent patient with an underlying clinical cause

It was agreed that the CPG would not be created in isolation and that policy and procedure should support it. When considering restraint, it was decided to agree the principles before issuing any guidelines. Mark Doyle highlighted the importance of capacity assessment, which is based on the opinion of the practitioner at any given time, and in good faith. He identified a need for further training around capacity assessment and suggested some scenario based training. Geoff King mentioned that there is a Mental Health Transport Team based in Naas and endeavoured to find out more information on the service they provide. Lawrence Kenna suggested that the group commission Denis Cusack to review the CPG, policy and procedures, once they have been agreed by MAG. It was brought to the meeting's attention that the Mental Capacity Bill is being progressed through the Dáil and it may be appropriate to make a submission in relation to providing protection to practitioners when dealing with patients who lack capacity but require urgent medical attention.

Position paper Clinical Practice Guidelines implementation

Included in the meeting papers was a position paper detailing options of structured timeframes for the implementation of CPGs. This paper had been presented to Council, who referred it to MAG for input. The Director indicated that PHECC are leaning towards publishing CPGs biannually, unless there was an urgent need identified to disseminate a new one. Macartan Hughes indicated that the last alternative in option 2 and options 3 & 4 would be the NAS approach and Martin O' Reilly agreed that DFB would probably adopt the same approach. Mark Doyle suggested that PHECC introduce the implementation guidelines ahead of them going live, in order to prepare practitioners, RI's and CPG approved organisations. Lawrence Kenna asked how PHECC define 'up to date'. The Director informed the group that practitioners would have to tick and sign the re-registration form to state that they are CPG current. Niamh Collins stated that CPC should look after upskilling. It was agreed to develop a framework to suit the requirements of individuals, CPG approved organisations and RI's and that dates would be agreed for old CPGs to be withdrawn. It was agreed to remove the requirement to have 40% and 80% of practitioners updated within the specified timeframes and make it mandatory that 99% of practitioners be updated within eighteen months. Option 3 was changed from three years to eighteen months. There was also a suggestion that RI's would have in place an update programme within six months. Option 4 was also changed from three years to eighteen months. Practitioners once competent may initiate practices on CPGs. Updating of CPGs to be tied into CPC and re-registration.

4. Pre-Hospital Paediatric Pain Management Study

Following on from the presentation, made by Dr Adrian Murphy and Prof Ronan O' Sullivan in October last, a recommended CPG outline for paediatric pain management was included in the papers, along with a briefing document on the Current and Future Trends in Pre-hospital Paediatric Analgesia in Ireland. Brian Power made some recommendations, based on Dr Murphy's submission and a draft CPG was included in the papers for approval, along with an interim directive for the use of Fentanyl IN on paediatric patients. Cathal O' Donnell expressed some concern that Fentanyl is not on the medication schedule and it may take some time to get approval from the Irish Medicines Board (IMB). The Director suggested that he and Brian Power meet with the IMB and Sean Walsh advised that the IMB have previously approved the use of Fentanyl IN for another research project; this may assist in getting it authorised pre-hospital. Macartan Hughes confirmed that the NAS would require a formal request prior

to contributing to the trial; as would DFB. Mark Doyle stressed the importance of how the trial is managed within the services, as only a limited number of practitioners (120 approximately) will be involved in it. Niamh Collins suggested that the proposed age of a paediatric patient on this draft CPG (≤ 16 years) could have implications on other CPGs. Sean Walsh confirmed that, going forward, the NCH and National Paediatric Programme definition of a child will be 'under the age of 16'. Cathal O' Donnell stressed that clear direction would have to be given and claimed that there would be a huge logistical issue in using Fentanyl, with only some practitioners involved, particularly when the proposed age limit of a paediatric patient conflicting with all other CPGs. He stated that the proposed age limit would also have implications for the administration of Paracetamol and Ibuprofen, as well as Fentanyl. The Director suggested that, for the purpose of the trial, MAG agrees that the interim directive be used in all instances, and the cases would not be documented unless the patients are transported to one of the five participating hospitals. It was acknowledged that potentially a large number of cases would be lost from the trial if transported to other hospitals or if the age limit of paediatrics decreased to ≤ 13 on the CPG. Some further discussion suggested that the age on this CPG be realigned with all other paediatric CPGs (≤ 13 years) and Martin O' Reilly also suggested a separate CPG for adolescents, to capture patients from 13-16 years. Sean Walsh recommended that MAG review the age profile of all paediatric CPGs. The following was agreed:

- That the Research Study Group from OLCHC independently write to NAS and DFB, inviting them to participate in the trial
- PHECC will independently approach the IMB and support the application from NAS and DFB to modify their licence to incorporate the use of fentanyl IN
- When corresponding with the IMB, refer to the 'trial' as a 'feasibility study'
- That draft CPG 4/5/6.7.14 be amended to reflect the paediatric age of (≤ 13 years) and that intranasal fentanyl be used in the management of severe pain only (6 or greater on the PHECC paediatric pain ladder)
- That the pain assessment recommendation on draft CPG 4/5/6.7.14 be amended to read ' ≥ 8 years use analogue pain scale'
- That a new CPG be drafted for adolescents (13-16 years), using the same framework as the paediatric CPG
- The interim directive be changed to reflect the amendments to the CPG and proposed new CPG for adolescents
- The CPGs are to be introduced on a limited targeted basis

Resolution: That draft CPG 4/5/6.7.14 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Martin O' Reilly

Seconded: Macartan Hughes

Carried without dissent

Resolution: That a new CPG be developed for adolescents (13-16 years), using the same framework as the paediatric CPG, incorporating the changes outlined above.

Proposed: Sean Walsh
Carried without dissent

Seconded: Declan Lonergan

5. Scope of Practice for Post Graduate Interns

A definition of 'intern' along with scope of practice details of interns from the Medical Council and UCD School of Nursing and Midwifery were included in the papers for discussion. Brian Power also detailed some draft options for the pre-hospital practitioner internship for further discussion. The Director sought advice on the proposed options, in relation to terminology and what parameters are put around paramedics at different stages in their course. The Director informed the group that PHECC are currently considering devolving the OSCE part of the paramedic exam to the recognised institutions, to allow them introduce more practical scenario based assessment. This, he feels is timely as PHECC want to move towards tertiary organisations providing training and examining. A suggestion was made that perhaps some time should be taken off the post graduate internship. Sean Walsh stated that autonomy is the key for interns and informed the group that medical interns can treat patients, without supervision, but cannot discharge. Cathal O' Donnell reiterated a previous concern that post graduate interns don't have back up support if they aren't crewed with a registered paramedic. A memo from the NAS Medical Director was disseminated to the group, detailing that post graduate interns are not permitted to be rostered with EMT's and that managers should seek to minimise instances of post graduate interns crewing together. It also confirmed that from 1st January 2013 NAS will only permit post graduate interns to work alongside fully registered paramedics. The Director acknowledged that these new NAS guidelines exceed the current PHECC standard and raised a concern that if the guidelines, as detailed in the NAS letter, are applied to APs then the AP programme would be in jeopardy. Some concern was raised over solo responders at AP level, although it was acknowledged that they have access to experienced consultant advice through the AP emergency line, which has been set up in CUH. Mark Doyle said that there is no difference in practice in terms of paramedic or post graduate intern and feels that this is fundamentally flawed and needs to be addressed as a matter of priority. The Director agreed to work further on a proposal which will be brought back to the next meeting for further discussion.

6. Draft Definitions for PHECC Practitioners

Brian Power sought the advice of the group on draft clinical definitions for PHECC practitioners, which incorporates their scope of practice. Sean Walsh suggested stating that all practitioners work under CPGs. Martin O' Reilly suggested including 'referral' in the paramedic definition.

7. AOB

Brian Power tabled correspondence from Martin O' Reilly, which referred to a query raised by DFB tutors, who questioned when a paramedic can perform advanced airway management on a patient. It was confirmed that paramedics may insert an advanced airway – supraglottic device on patients who are ≥ 8 who meet the criteria set out in the CPG. It was agreed to modify the VF or Pulseless VT – Paediatric (≤ 13 years) and Paediatric Asystole CPG in the future.

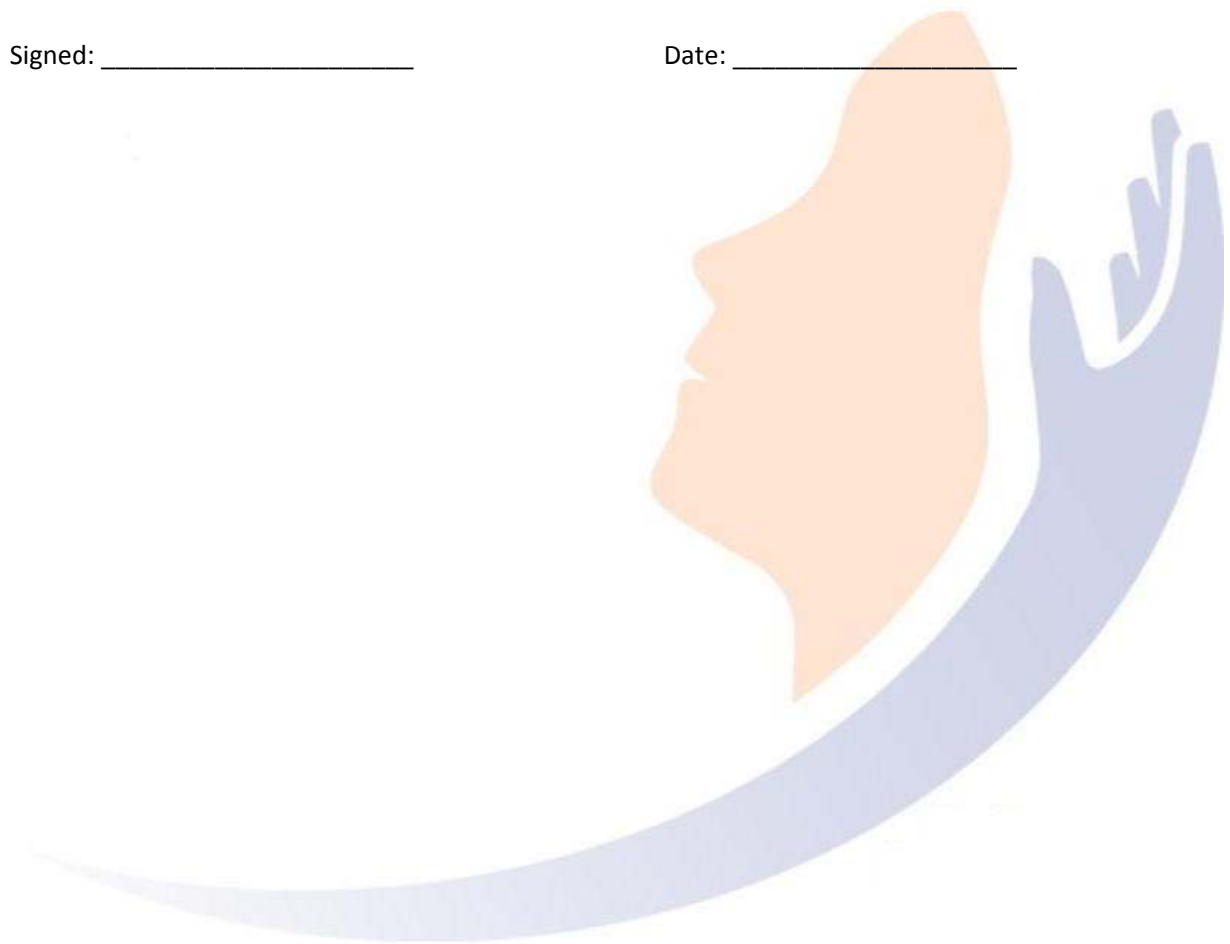
Cathal O' Donnell briefly mentioned that Ireland is hosting the International Conference of Emergency Medicine in June of this year and registration for the conference is now open.

Lawrence Kenna requested clarification on the use of oral morphine. It was confirmed that currently it cannot be used for adults, however the group agreed to re-look at the CPG.

The next meeting will take place on Thursday 23rd February 2012. The Chair thanked members for their attendance. There being no further business the meeting concluded.

Signed: _____

Date: _____



The Medical Advisory Group
Meeting Minutes 23rd February 2012, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O'Reilly
Frank O'Malley
Conor Egleston
Gerald Kerr
Niamh Collins
Mark Doyle
Lawrence Kenna
Sean O'Rourke

cdt.

Brendan Whelan
Macartan Hughes
Declan Lonergan
Stephen Cusack
Sean Walsh

Present

Geoff King (Director)
Brian Power
Deirdre Borland

Apologies

David Menzies
Cathal O'Donnell
Valerie Small
Peter O'Connor
David Janes

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. The chair also welcomed a new member to the group, Dr. Gerald Kerr.

The Director discussed the feasibility of inviting the ICGP to formally nominate a candidate as a representative on MAG in order to ensure that PHECCs initiatives are communicated to this important stakeholder group. Stephen Cusack remarked that in light of there being a number of GPs already represented on the MAG that it may be easier for an existing member to fulfil this function. The Director indicated the ICGP may have specific members who have a mandate to formally communicate to their members.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 26th January 2012 be approved.

Proposed: Macartan Hughes
Carried without dissent

Seconded: Niamh Collins

3. CPGs

▪ **4/5/6.7.4 Secondary Survey – Paediatric (≤ 13 years)**

Following a request for the updated Secondary Survey – Paediatric CPG to be returned to the February meeting it was included in the meeting papers for reference. Niamh Collins suggested that the word "indicators" be amended to "concerns" in relation to child protection. The Director asked Sean Walsh to

confirm that the formula stated on the CPG was safe for pre-hospital practice. Dr Walsh indicated that the formula was appropriate for use in the field and recommended that it be referenced on the CPG. It was also suggested that the box 'observe both patient and guardian' be removed and that 'interaction with guardian' be included in the previous box.

Resolution: That the Secondary Survey – Paediatric CPG be recommended to Council for approval subject to the changes outlined above.

Proposed: Sean Walsh
Carried without dissent

Seconded: Mark Doyle

▪ **4/5/6.7.1 Primary Survey Medical – Paediatric (≤ 13 years) and 4/5/6.7.2 Primary Survey Trauma – Paediatric (≤ 13 years)**

At the February meeting it was suggested that the primary survey – Paediatric CPGs should also refer to child protection issues. Both Primary Survey Medical – Paediatric and Primary Survey Trauma – Paediatric were tabled for information with the child protection box included. It was agreed, similarly to the Secondary Survey – Paediatric CPG, that word "indicators" be amended to "concerns". It was also agreed that the reference to the National Guidance for Protection and Welfare of Children be included on both CPGs.

Resolution: That the updated Primary Survey Medical - Paediatric and Primary Survey Trauma – Paediatric CPGs be recommended to Council for approval subject to the changes outlined above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Lawrence Kenna

▪ **Patient restraint policy and procedure document**

Brian Power gave the background of the draft patient restraint policy and procedure document which was included in the meeting papers. The policy is designed to support the restraint element of the Behavioural Emergency CPG as requested at the February meeting.

Conor Egleston asked if PHECC had sought legal opinion prior to drafting the policy. The Director stated that it was PHECCs intention to design a best practice guideline and then seek legal advice as alluded to in previous meetings.

Gerald Kerr complimented the work undertaken on the policy and procedure document and stated that he felt it was a good policy which covered the basics well. Niamh Collins stated that she has some concerns regarding the tone of the policy, in particular the use of the word "restraint" and the possible implications for the patient/practitioner relationship.

Frank O'Malley expressed concern about patients who unexpectedly has an adverse/violent behavioural episode during transport and requested, for both practitioner and patient safety, that something be included in the policy regarding this occurrence.

Sean Walsh expressed a concern that the policy does not have a strong enough emphasis on the assessment of capacity. He also asked that the policy specifically incorporate children. Mark Doyle agreed that more detail should be included on the issue of capacity.

The Director suggested that the office undertake further work on the policy focusing on children and capacity and revisit the issue at the next meeting.

A draft CPG on behavioural emergencies was tabled for information. Martin O'Reilly requested that in order to protect practitioners the box on the current CPGs in relation to not compelling a patient to travel in the ambulance or prevent the patient from leaving the ambulance should be included in the updated CPGs on behavioural emergencies.

▪ **Mental Capacity Bill**

Brian Power introduced a Submission to the Oireachtas Committee on Justice and Equality in relation to Mental Capacity Legislation. Niamh Collins stated that she felt that it would be prudent for MAG to ask the Oireachtas Committee to include formal advice regarding care and transport of minors (< 18 years) who refuse care and/or transport in an emergency who; a) demonstrate capacity, and b) do not demonstrate capacity. Stephen Cusack also suggested that clarification also be sought regarding intoxication (alcohol and/or drugs) and capacity.

Resolution: That the MAG submit to the Oireachtas Committee on Justice and Equality the presented document and seek clarification in relation to i) consent of minors and ii) capacity following intoxication.

Proposed: Mark Doyle
Carried without dissent

Seconded: Stephen Cusack

▪ **Suspension Trauma**

Following a request for clarification from the Defences Forces on care of a patient as a result of suspension trauma Brian Power presented the Health and Safety Executive (UK) comprehensive research on this topic. A first draft of Suspension Trauma CPGs for both practitioners and responders was introduced. Martin O'Reilly asked if it was necessary to include 'transport to a facility with dialysis'. The group agreed to remove the reference to dialysis from the CPG. Both CPGs shall be put through the Delphi process.

4. Pre-Hospital Paediatric Pain Management Study

Brian Power explained that an update on the dose of Fentanyl was received too late for inclusion in the meeting papers. The Pain Management - Adolescence CPG was tabled for discussion. Sean Walsh proposed the following amendment to the CPG: i) Age should be stated as $14 \leq 15$ years, ii) Delete reference to 16 years for Fentanyl dose calculations, iii) A maximum of 100 mcg per dose be included.

Resolution: That the Pain Management – Adolescent ($14 \leq 15$ years) CPG be recommended to Council for approval subject to the changes outlined above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Macartan Hughes

5. Scope of Practice for Post Graduate Interns

MAG was requested for their feedback on the updated draft proposal for Scope of Practice for Post Graduate Interns. Macartan Hughes stated that it would not be feasible to move the NQEMT exam to 3 months earlier without significant changes to the undergrad internship. He also stated that he didn't believe that a practitioner should be permitted to solo respond without a minimum of 1 year post graduate work experience.

It was agreed to discuss this issue in further detail at the next MAG meeting.

6. Haemostatic Dressings

Brian Power asked the group to consider the merits of including an impregnated haemostatic dressing in the equipment list for practitioners in circumstances of significant haemorrhage. Gerard Kerr informed the group that the Defence Forces currently use such products and advised caution as specific brands may be dependant of the patients individual coagulation abilities and therefore unsuitable in certain circumstances such as hypothermia. Stephen Cusack also highlighted the vast differences in costs and shelf life between various brands. Brian confirmed that if the group deem the inclusion of haemostatic dressings is beneficial, no brand name would be specified and it would be the choice of the individual services which product they purchase. Brian will bring a draft CPG to the group at the next meeting.

7. AOB

7.1 National Acute Coronary Syndromes Programme

Brian Power presented the latest draft from the National Acute Coronary Syndromes programme. The group asked that the Director bring the following feedback to the National ACS programme.

- Correct the working of National Ambulance Service as this currently excludes Dublin Fire Brigade
- Replace the term ACLS with ALS
- Replace the term STEMI with ACS

It was noted that the initial 3 hour window from onset of symptoms for thrombolysis is no longer the preferred option of the ACS programme. It was suggested that this be removed from the ACS CPG. There was no dissent to this.

It was thought unnecessary and unachievable to have an ALS trained medical practitioner to accompany a STEMI patient, (whether or not thrombolised) from the hospital of first presentation to the PPCI centre. This was more the remit of Emergency Departments/the Emergency Medicine Programme/Hospitals/the Acute Medicine Programme than PHECC but the Director would convey this to the ACS along with the other editing suggestions.

Brendan Whelan asked that Paramedics should be able to administer Clopidogrel as they are trained in the identification of STEMI. There was no dissenting voice in relation to this proposal; however it was not clear during the meeting whether or not Clopidogrel was on the 7th Schedule which authorises administration of medications by pre-hospital emergency care practitioners. The Director indicated that

this will be progressed; in the meantime it is permitted for paramedics to administer Clopidogrel under a doctor's direction, in this instance the Cardiologist/Registrar at the PPCI centre.

Brian Power will come back to the group a definitive answer on the 7th Schedule and with an updated ACS CPG showing amendment regarding the 3 hour treatment window.

7.2 Handover Process

Martin O'Reilly received a request for clarification from the Emergency Care Programme regarding the process of meeting the KPI to achieve a 20 minute turnaround for patient handover at the emergency department. Macartan Hughes, Brendan Whelan agreed to coordinate with Martin to compile a best practice guideline regarding handover.

The next meeting will take place on 29th March 2012. The Chair thanked members for their attendance. There being no further business the meeting concluded.

Signed: _____

Date: _____



The Medical Advisory Group

Meeting Minutes 29th March 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)

Gerry Bury

Martin O'Reilly

Peter O'Connor

Macartan Hughes

Gerald Kerr

Cathal O'Donnell

Valerie Small

Lawrence Kenna

Sean Walsh

Brendan Whelan

Present

Geoff King (Director)

Brian Power

Deirdre Borland

David Menzies

Apologies

Mark Doyle

Sean O'Rourke

Niamh Collins

David Janes

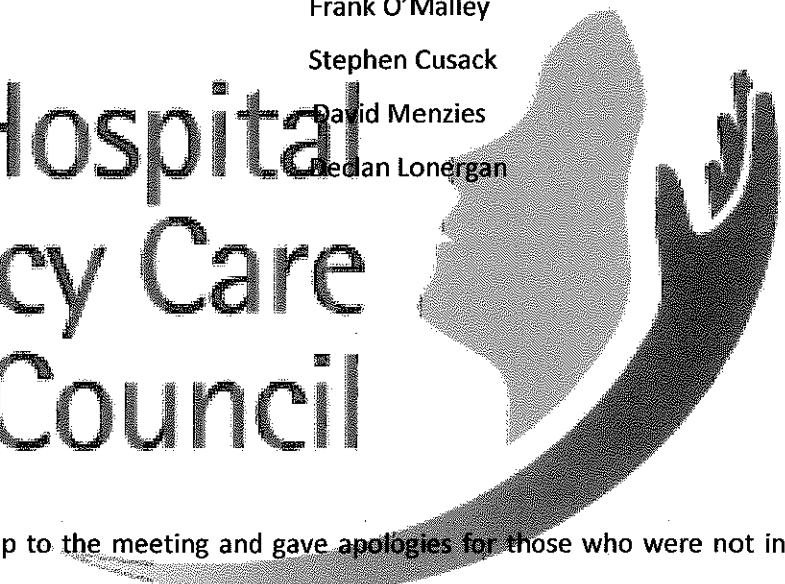
Frank O'Malley

Stephen Cusack

David Menzies

Brian Loneragan

Pre-Hospital Emergency Care Council



1. Chair's business

The Chair welcomed the group to the meeting and gave apologies for those who were not in attendance. She expressed her sympathy to the PHECC staff and in particular the family of Marie Ní Mhurchú, Client Service Manager from the PHECC office who recently passed away.

2. Meeting Report – 23rd February 2012

Resolution: That the minutes from the Medical Advisory Group meeting held on the 23rd February 2012 be agreed.

Proposed: Brendan Whelan

Seconded: Martin O'Reilly

Carried without dissent

3. CPG's

3.1 Suspension Trauma

Brian Power gave an account of the feedback received from the Delphi process undertaken regarding the proposed Suspension Trauma CPG. He indicated that there were some suggestions to change the CPG title to Harness Induced Suspension Trauma to avoid any confusion with "hanging".

Sean Walsh raised a concern regarding the use of Sodium Bicarbonate, as it is administered in hospital under controlled titration and analysis of PH which would be unavailable to practitioners in the field. Brian Power referenced an article which appears in Wilderness and Environmental Medicine advocating the use of Sodium Bicarbonate.

The Chair suggested that while not directly impacting on this CPG, with the proliferation of prescribing tricyclics for conditions other than depression, it is wise to consider the availability of sodium bicarbonate for practitioners.

Martin O'Reilly asked that sodium Bicarbonate be limited to "adult cardiac arrest" on the CPG.

Gerry Bury and Gerard Kerr were in agreement that a direction should be included to "remove the harness if possible" if circulation is compromised.

Resolution: That the Medical Advisory Group recommends the Practitioner level Harness Induced Suspension Trauma CPG to Council for approval subject to the changes outlined, including "if circulation is compromised remove harness".

Proposed: Brendan Whelan

Seconded: Peter O'Connor

Carried without dissent

Resolution: That the Medical Advisory Group recommends the Responder level CPG Harness Induced Suspension Trauma to Council for approval subject to the changes outlined.

Proposed: Macartan Hughes

Seconded: Valerie Small

Carried without dissent

Pre-Hospital
Emergency Care
Council

3.2 ACS CPG

Brian Power introduced the amended Cardiac Chest Pain – Acute Coronary Syndrome CPG for the group's approval. He outlined the changes from the previous version. The group asked for the following further amendments to be undertaken:

1. Replace point 4 – MI symptoms \leq 3hrs with "MI Symptoms 20mins to 6 hours"
2. Point 3 be reworded to aid clarification – include if $>$ 75 years
3. An upper time limit be specified ideally 6rs
4. Under special instructions insert "if clinically indicated" and delete "Following 12 lead ECG interpretation"
5. Change the CPG name to ACS
6. Change transport to PPCI centre to nearest appropriate hospital in the special instructions
7. Change "ED with thrombolysis therapy" to nearest appropriate hospital.
8. Following pre-hospital thrombolysis change transport to "PPCI" with "nearest appropriate hospital"
9. Change Clopidogrel to Paramedic medication. In the absence of approval under the 7th schedule and special authorisation, the medical Directors of the approved CPG organisations will be required to sign an interim directive to permit paramedics to administer Clopidogrel legally.

Pre-Hospital
Emergency Care
Council

The group requested that the ACS CPG be tabled at the next MAG meeting with the changes incorporated to ensure that all the issues are addressed.

3.3 Haemorrhage

Brian Power introduced the changes to the External Haemorrhage – Adult CPG which allow for the application of a haemostatic agent in cases of catastrophic haemorrhage as discussed at the previous MAG. Gerard Kerr asked that the application of a tourniquet be indicated early in the stage of the CPG for catastrophic haemorrhage. Gerry Bury agreed with this suggestion, including allowing the application of a tourniquet at responder under special direction from a medical practitioner.

Brian agreed to redraft the CPG with the suggested changes and bring it back to the next meeting.

3.4 Behavioural Emergencies – patient restraint policy

Brian introduced a draft policy to support the behavioural emergency CPG. An email received from David Janes strongly objected to the inclusion of any form of patient restraint carried out by practitioners. Lawrence Kenna said that while the policy was well written he too could not condone the inclusion of physical restraint within a CPG. Martin O'Reilly, Brendan Whelan, Gerry Bury all concurred with this stance. Brian cautioned that it is not intended that practitioners would solely engage in restraining patients that An Garda Síochána would be involved.

Gerard Kerr asked if in the extreme case where a practitioner's safety was under immediate threat, for example while in transit and alone with the patient who becomes violent must have means of self defence.

The Director informed the group that his experience of patient restraint in Australia was typically carried out with the patients consent or on an unconscious patient.

Cathal O'Donnell suggested that elements of the policy could be applied in the case specifically of aviation transport.

It was agreed to revisit.

Pre-Hospital Emergency Care Council

3.5 Clinical Practice Guidelines implementation timeframes

Brian Power introduced a Council policy: Implementation timeframes of Clinical Practice Guidelines (CPGs) for information. Margaret Hughes indicated the adhering to the 99% compliance rate due to levels of long term sick etc. could be problematic. The policy was discussed and it was clarified that organisations had 18 months to ensure that their practitioners were updated/upskilled as relevant. It was acknowledged that this may create operational difficulties. The Director assured that PHECC would remain fair and understanding in their dealings with CPG approved organisations and should major difficulties be incurred the organisation can make representation.

4. KPI – update

The Director gave an update on a recent Key Performance Indicator meeting chaired by Mark Doyle. He informed the group that the meeting benefited from very worthwhile presentations from Mark Doyle, Gerry Bury and Ronan O’Sullivan. The AQUIP group will now identify key stakeholders and a process to develop key performance indicators and PHECC will participate and underwrite the process.

5. Continuous Professional Competency (CPC)

- A Guide for EMTs registered with PHECC

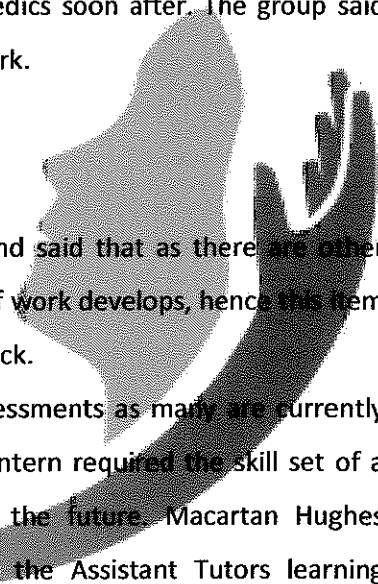
The Director gave a background to the work undertaken by Shane Knox, who is undertaking a PhD on CPC. The Director outlined the scope of the project and proposal for CPC initially for EMTs but would incorporate Paramedic and Advanced Paramedics soon after. The group said that Shane should be complimented on an excellent piece of work.

6. Scope of Practice for Post Graduate Interns

The Director gave an account of work undertaken thus far and said that as there are other initiatives that will have a profound impact on how this piece of work develops, hence this item is currently on short term hold but welcomed the groups feedback.

Lawrence Kenna asked if Assistant Tutors could carry out assessments as many are currently PHECC examiners. The Director indicated that assessment of Intern required the skill set of a Tutor, but PHECC would consider representations made in the future. Macartan Hughes suggested that an assessment module could be build into the Assistant Tutors learning programme.

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7. EMS priority dispatch

Brian Power gave a synopsis of the work of the EMS Priority Dispatch Subgroup and the resulting amendments to the DCR table. Martin O'Reilly asked that the phrase "AP not required" be changed to "AP need not be deployed" to leave some discretion with the dispatcher. Brian also outlined that there was four possible outcomes for Omega calls.

- Ambulance required
- Non clinical transport required
- Make own arrangement for transport
- Clinical advise required

However, until such time as appropriate clinical advice provided in a structures way it cannot be implemented.

Cathal O'Donnell asked that the appropriateness of including Expected Death Situation being included in this category be examined. Zella Gaffney suggested that the direction of go to GP be changed to go to nearest GP service to include out of hours regional GP services.

Cathal O'Donnell informed the group that there are logistical challenges for NAS in providing Paramedics with Midazolam for seizure calls; as a result he requested that APs continue to be deployed until this issue is addressed.

It was suggested that future changes to the DCR table be approved by MAG rather than Council to facilitate a speedy change when it is required.

Resolution: That the draft EMS Priority Dispatch Standard be recommended to Council for approval and that the Medical Advisory Group approves future changes to the DCR table.

Proposed: Peter O'Connor

Seconded: Macartan Hughes

Carried without dissent

8. CFR – Report to PHECC Council – for Information

A report on the progress of the CFR Community and CFR Advanced courses was included in the meeting papers and was noted by the members.

9. A.O.B

The Emergency Medicine Programme provided MAG with their draft suggested national standardised handover information process between the pre-hospital practitioner and ED staff. Valerie Small informed the group that further developments will be forthcoming. New South Wales handover research paper will be circulated to MAG members for information.

An email from an AP was circulated asking for MAG to considering sanctioning appropriate level Practitioners to officially pronounce death as there has been many instances of practitioners having to remain on scene for long periods while awaiting a doctor to pronounce. The Director indicated that no change in law would be required to formalise this and that the issue was being addressed by the end of life forum.

An email was received from a practitioner asking that the PHECC website host all clinical directives from clinical directors of CCG approved organisations. Cathal O'Donnell informed the group that the NAS clinical directives are available publicly on the HSE website. The Director concurred that it is the role of each Medical Director to effectively communicate directives and not PHECCs place to host such announcements.

An email from an AP asking for direction regarding the difference between contraindications listed in the medication formulary for Diazepam and Midazolam. Cathal O'Donnell suggested that due to the pharmacological similarities if these drugs the listed contraindications be brought into line to avoid confusion.

Resolution: That the Medical Advisory Group amend the contraindications for Diazepam and Midazolam be brought in line with each other.

Proposed: Peter O'Connor

Seconded: Lawrence Kenna.

Carried without dissent

It was agreed that the next MAG meeting would be held on 26th April at 10:00am. There being no other business the chair thanked the group for their contribution and called an end to the meeting.

Signed: _____

Date: _____

Pre-Hospital Emergency Care Council



The Medical Advisory Group

Meeting Minutes 26th April 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Gerry Bury
Martin O'Reilly
Niamh Collins
Macartan Hughes
Declan Lonergan
Cathal O'Donnell
Valerie Small
Lawrence Kenna
Brendan Whelan

Present

Geoff King (Director)
Brian Power
Deirdre Borland

Apologies

Mark Doyle
Sean O'Rourke
Gerald Kerr
Stephen Cusack
David Janes
Frank O'Malley
Peter O'Connor
David Menzies
John O'Donnell

1. Chair's business

The Chair welcomed the assembled members to the meeting. She advised the group that Adrian Murphy has requested that he attend the next MAG meeting to present his interim findings on the "Fentanyl project".

2. Minutes and Matters arising.

Resolution: That the minutes from the Medical Advisory Group meeting held on the 29th March 2012 be agreed subject to any typographical errors being amended.

Proposed: Macartan Hughes

Seconded: Valerie Small

Carried without dissent

3. Emergency Medicine Programme Ambulance Handover SOP

Valerie Small gave apologies for Fiona McDaid who at the last minute could not attend. The intention was to present to the group an account of progress thus far in the development of the ambulance handover policy. Valerie, a member of a sub-group within the Emergency Medicine Programme who developed the policy, informed the group that the protocol will form a KPI for the Emergency Medicine Programme, which aims to standardise the handover process between Paramedics and each Emergency Department nationwide. It will also provide a platform for the development of use of the Patient Care Report (PCR).

The group were highly complimentary of the work undertaken and some suggestions were made regarding changes in terminology to ensure that the policy remain generic and inclusive for all pre-hospital emergency care service providers and their Practitioners.

Declan Lonergan stressed the importance of Practitioners being able to identify the correct person within the Emergency Dept to engage in the handover process with and that training will be important for all stakeholders. He indicated that a definition of handover should be included in the policy to aid clarity for all concerned.

Lawrence Kenna asked that the handover of the PCR not be used as a pre-requisite for registering patients which is currently happening in some Emergency Depts. There was widespread agreement that this should not be the case and the individual Emergency Dept staff should be informed that the PCR is not required in order to register a patient.

Gerry Bury stated that he supported the development and requested that ED handover staff should be more identifiable by wearing a coloured tabard or similar. He further suggested clarifying to ED staff that practitioners are responsible to care for and medicate a patient until the point of handover would be a useful exercise. He also asked if the issue of pre-alerts be developed.

Cathal O'Donnell indicated that there are currently two alert systems in place in Limerick, request resus and request assessment on arrival; both of which are working to the advantage of the ED staff and Practitioners.

The Director asked that rather the specifying that the Practitioner be thanked, the importance of collaborative working and mutual respect be highlighted. The Chair said that there was still a place for thanks and in addition there should be an avenue of follow up for Practitioners to assess the outcomes for the patient to whom they had given care.

Brian Power suggested that some representatives from MAG should make themselves available to the Emergency Medicine Programme to aid in the development of this important policy as pre-hospital emergency care Practitioners are important stakeholders in this development. Valerie Small invited all members of the group to submit their feedback to the PHECC office for her attention.

Resolution: That Declan Lonergan and Niamh Collins make themselves available to represent MAG on the sub group of the Emergency Medicine Programme to develop a national handover process.

Proposed: Lawrence Kenna

Seconded: Macartan Hughes

Carried without dissent

4. CPGs

4.1 ACS CPG

A final draft of the ACS CPG was included in the meeting papers for the group's approval.

Declan Lonergan asked for clarification of when the clock stops regarding the given 90 minute timeframe for transport to hospital. He expressed a concern that by indicating specific timeframes that potentially high speed transport could be placed as a priority over patient care during transport. The Director indicated that the Practitioners would only be advised to transport the patient to a facility if they were within a comfortable and safe 90 minute distance of the PPI centre. He said that the 90 minute time window relates to arrival at the hospital not to a time of intervention.

The Chair asked that Cathal O'Donnell give an update to the group once the ACS PCI project has been implemented for 6 months.

Brian Power explained that there is a need for an Interim Directive for Clopidogrel for Paramedics as it is not currently on the Medicinal Products schedule.

Due to the proposed introduction of the ACS programme recommendations on primary PCIs the new ACS CPGs is required to be included into the April release of CPGs.

Resolution: That the Medical Advisory Group recommends the Practitioner level ACS CPG 5/6.4.16 to Council for approval.

Proposed: Brendan Whelan

Seconded: Declan Lonergan

Carried without dissent

4.2 Haemorrhage Control

Two updated CPGs for the treatment of external haemorrhage (Responder and Practitioner levels) were included in the meeting papers for the group's approval.

Macartan Hughes suggested that request ALS be included in the CPG at the point of identification of catastrophic haemorrhage.

Niamh Collins asked that the basics of PEEP not be forgotten for the treatment of catastrophic haemorrhage when applying a tourniquet. She requested that PEEP be also included in the CPG at the point of identification of catastrophic haemorrhage.

Resolution: That the Medical Advisory Group recommends the Practitioner level External Haemorrhage - Adult CPG 4/5/6.6.1 to Council for approval subject to the changes outlined.

Proposed: Macartan Hughes

Seconded: Cathal O'Donnell

Carried without dissent

The group agreed that similar changes be made to the responder level CPG, substituting '999' for request 'ALS'

Resolution: That the Medical Advisory Group recommends the Responder level External Haemorrhage CPG 2/3.6.1 to Council for approval subject to the changes outlined.

Proposed: Macartan Hughes

Seconded: Valerie Small

Carried without dissent

5. Meningitis Research Foundation Card

The Meningitis Research Foundation has drafted an updated aid for Ambulance Personnel for the identification and management of meningococcal septicaemia. They sought approval from PHECC for its contents. The aid was included in MAG papers for deliberation.

The following points were raised:

Niamh Collins suggested that the title would be more inclusive if it read 'Meningococcal Infection' with "Meningitis or Meningococcal Septicaemia" as a sub heading. She suggested that both meningitis and meningococcal septicaemia be differentiated in the text with an explanation of the crossover of both.

Also point 5 of Management should read 1 litre and repeat if ongoing signs of poor perfusion and not 250 mL to be consistent with the CPG. She suggested that the signs and symptoms list in ABC format would be more useful.

Change 'Some symptoms may be absent and the order in which they appear may vary' to 'Symptoms may appear in any order or may not appear at all'

Lawrence Kenna suggested that the signs and symptoms should be compressed into one flow chart on page 2 stating with or without rash.

The flow chart on page 2 should be updated to reflect the CPG, treat with benzylpenicillin if suspected meningococcal infection.

Macartan Hughes asked that the age restriction on <7 years be removed from the IO administration on benzylpenicillin.

The Chair asked that the aid should read Meningococcal Infection (Septicaemia) throughout the text.

Brian Power agreed to make the suggested changes and pass on the groups recommendations to the Meningitis Research Foundation.

6. AOB

6.1 Paediatric antiemetic administration

An email received by from an AP requesting that the Nausea and vomiting CPG be made applicable for paediatric cases. Some members expressed caution.

Niamh Collins suggested that in the absence of Sean Walsh the group should not make a decision on this issue without his input. Brian Power agreed to follow up with Sean Walsh on the issue.

6.2 Do not resuscitate orders.

Martin O'Reilly informed the group that he had a request from a practitioner to clarify some issues around DNR orders. Namely, who/what is considered as a clinical source and what is considered as recent and reliable evidence?

The Director allowed that this was a very difficult area with many vagaries for Practitioners. He stressed that work is currently underway by the End of Life Forum which may prove beneficial. He indicated that he will approach the forum and the palliative care group to ascertain if there are any developments forthcoming. Cathal O'Donnell suggested that MAG engage with Dr Karen Ryan, Consultant Physician in Palliative Care Medicine, St Francis Hospice, & National Lead Clinical Care Programme in Palliative Medicine, to help produce a guidance document for Practitioners.

6.3 Pronouncement of Death

Macartan Hughes asked if there were any developments regarding the feasibility of Paramedics being able to pronounce death. The Director informed those present that he had communicated this request to the End of Life Forum currently have the issue under consideration.

6.4 Children First - National Guidance for the Protection and Welfare of Children

Niamh Collins asked if pre-hospital practitioners were specifically identified as a group with responsibility for care of children within the Children First document. She stressed the importance of Practitioners being protected while raising concerns regarding child safety to the relevant authorities. It was suggested that this be revisited at the next MAG meeting.

It was agreed that the next MAG meeting would be held on May 31st with the following meeting scheduled for 21st June at 10:00am. There being no other business the Chair thanked the group for their contribution and called an end to the meeting.

Signed: _____

Date: _____

The Medical Advisory Group

Meeting Minutes 31st May 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Gerry Bury
Martin O'Reilly
Niamh Collins
Macartan Hughes
Declan Lonergan
Cathal O'Donnell
Valerie Small
John O'Donnell
Sean Walsh
Gerald Kerr
Stephen Cusack
Mark Doyle
Peter O'Connor

Present

Geoff King (Director)
Brian Power
Deirdre Borland
Adrian Murphy
Ronan O'Sullivan

Apologies

Lawrence Kenna
David Menzies
Frank O'Malley

1. Chair's business

The Chair welcomed the assembled members to the meeting. She advised the group that she and the Director will meet with a representative from the ICGP to develop a link with MAG and PHECC.

The Chair acknowledged the support demonstrated from MAG and PHECC during her recent bereavement.

Valerie Small thanked the group for feedback received regarding the Emergency Medicine Programme Ambulance Handover SOP. She committed to keep the group informed of developments with the SOP.

The Director reminded the group that the ICEM conference will be held in June. Ronan O'Sullivan offered 20 reduced price places to MAG members and their organisations at a pre-conference workshop entitled Pre-Hospital Research – FALCK Foundation. The Director thanked him for this offer and advised the members present to communicate with Deirdre Borland should they wish to take up this offer.

The Chair formally congratulated Niamh Collins on her appointment to the position of Consultant in Emergency Medicine at Connolly Hospital.

2. Minutes

Resolution: That the minutes from the Medical Advisory Group meeting held on the 26th April 2012 be agreed.

Proposed: Macartan Hughes

Seconded: Niamh Collins

Carried without dissent

2.1 Matters arising

Mark Doyle expressed a concern that the mapped timelines published by the ACS Programme are not achievable. Test runs have been carried out within the Waterford area which demonstrated that the timelines are not accurate. The Director suggested he communicate his concerns officially with the ACS Programme.

Brian Power asked Sean Walsh for his opinion regarding a request to make Ondansetron available for administration to paediatric patients for nausea and vomiting particular during long transfer times. Sean indicated that as the medication is currently use in hospital is relatively limited for nausea and vomiting he could not recommend that it be used in a pre-hospital setting for this indication without further evidence and research.

Martin O'Reilly asked if there was any update from the End of Life forum regarding do not resuscitate issues in pre-hospital settings. He asked that this be looked at urgently as it is posing a difficulty for practitioners; he cited getting approximately two calls per week from practitioners seeking guidance.

Discussion ensued on the End of Life Forum. It was felt that the issue raised should be addressed through that forum.

3. Update on Fentanyl Project

Dr. Adrian Murphy and Prof. Ronan O'Sullivan were invited to the meeting to give a presentation on the development of the Fentanyl project to the MAG. The project arose out of a knowledge gap regarding the pre-hospital administration of analgesics to paediatric patients, particularly pre verbal children. Adrian Murphy informed the group that the study is currently live in 7 emergency Departments with every child under 16 being targeted. A focus of the research is the effectiveness of Intranasal Fentanyl.

Arian Murphy synopsized a 3 month interim report stating that currently there is scope to greatly improve how paediatric pain is assessed and treated. The Director thanked Adrian for his

presentation of the study and work undertaken thus far and welcomed further findings to aid the MAG improve CPGs for the treatment of pain in paediatric patients.

Declan Lonergan called for improvements as to how assessment of pain is taught to practitioners during their training. Paul Lambert echoed this and asked that paediatric EDs allow practitioners interaction with paediatric patients during clinical placements. Gerry Kerr cautioned against the total suppression of pain as it does provide a protective function. The Chair asked that the ICGP be informed as it would be helpful if GP practices be made aware of the project. Adrian Murphy agreed to liaise with her on this.

4. KPI Update

A report by Ronan O'Sullivan, Adrian Murphy and Abel Wakai was circulated for the group's attention. Ronan O'Sullivan gave a brief overview of the study protocol which is currently at the literature review stage. They hope to identify potential KPIs and seek feedback and develop suggestions. He agreed to submit a proposal for funding to the Director within one month. Mark Doyle agreed to take the lead and determine the suitability of the proposal and report back to MAG.

5. CPGS

Brian Power introduced a suite of new treat and referral CPGs for initial feedback. These included exclusion criteria for entry to the treat and refer process. A discussion ensued regarding the practicalities of implementing a treat and refer process. Brian also informed the group that he is undertaking a PhD with treat and referral as his area of interest. Gerry Bury confirmed that he is acting as Brian's PhD supervisor.

Macartan Hughes asked the group to be cognisant regarding the training hours involved in implementing these CPGs.

Cathal O'Donnell stressed the importance of having a functioning Clinical Audit and Clinical Supervision system in place.

Gerry Bury cautioned that consideration be given to how such a process could potentially affect 999 calls and low acuity cases. He said that the dispatchers could have an important role in determining when an emergency vehicle should be dispatched. The Director informed him that the EMS Priority Dispatch group are currently investigating this.

Sean Walsh asked that protection for the Practitioner be at the core of any development and advised against creating a requirement for a new service such as NHS Direct.

Stephen Cusack asked that it not be forgotten that it is still the Emergency Departments duty to evolve to cater for all presenting patients rather than relying on other services to deflect certain cases.

Mark Doyle asked that other routes of treatment other than the Emergency Department be confirmed.

Brian Power asked the group to categorise which CPG presented they would be comfortable with developing. The following treat and Refer CPGs were chosen.

Proceed with development	Maybe for development	Not for development
<ul style="list-style-type: none">•Clinical care pathway•Hypoglycaemia•Isolated seizure•Epistaxis•Pepper spray•Toothache•Minor burns	<ul style="list-style-type: none">•Uninjured person• Minor Bites and Stings	<ul style="list-style-type: none">•Mild asthma•Palliative care•Minor wound•Vomitting and diarrhoea•Falls involving the elderly•Soft tissue limb injury•Minor head injury

Each of the CPGs agreed to proceed with development were then reviewed for initial feedback.

- *Clinical Care Pathway Options*

Cathal O'Donnell asked that the age of 16 be examined for legality regarding treat and refer. He also asked that the term "early warning score" not be used as it was not developed for pre-hospital use. The group agreed to change the age limit to 18 years to avoid any potential issue on age and to change "early warning score" to "normal vital signs".

Mark Doyle asked that a definition be put in place for community based health care professional. He stated that he did not agree with the exclusion of abdominal pain with cramping with V&D. He also asked that point 3 clinically obvious intoxication be more specific.

Macartan Hughes asked that obvious intoxication be changed to evidence of alcohol or drug excess.

Niamh Collins suggested that "poor social support" be changed to "vulnerable person"; this was not agreed upon as it was felt that a vulnerable person may have a good support network available to them. Niamh also suggested it be considered that Stroke/TIA should be included in category 13 Syncope and change Syncope to collapse; this needs consideration in relation to hypoglycaemia and seizure. It was pointed out that 'collapse' is too generic and that a high proportion of patients entering the treat & referral clinical care pathways would have initially collapsed.

Mark Doyle asked that the term "carer" be changed to "responsible adult".

- *Hypoglycemia Treat and Refer CPG*

Stephen Cusack asked that on oral hypoglycaemics should be added to exclusion box.

- *Isolated Seizure Treat and Refer CPG*

Mark Doyle asked that a timeline be include to take post seizure confusion into consideration.

Niamh Collins asked that two or more than more seizure in 24 hours be added to the exclusion box, as well as injury.

- *Epistaxis Treat and Refer CPG*

Mark Doyle asked that anticoagulant be added to the exclusion box. And control bleeding be changed to “stop bleeding”.

- *Pepper Spray Treat and Refer CPG*

Mark Doyle asked that respiratory condition be added to the exclusion box.

- *Localised Tooth Pain Treat and Refer CPG*

Stephen Cusack asked for the title to be changed to toothache. Niamh Collins asked that inability to open mouth fully be added to exclusion box. Mark Doyle questioned the appropriateness on the 48hr pathway.

- *Minor Burn Treat and Refer CPG*

Mark Doyle asked that non solar be added to the exclusion box after radiation burn.

6. AOB

The Chair thanked the group for their input and welcomed the excellent attendance to the meeting. The next meeting was scheduled for June 21st. There being no other business the meeting was ended.

Signed: _____

Date: _____

The Medical Advisory Group

Meeting Minutes 31st May 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Gerry Bury
Martin O'Reilly
Niamh Collins
Macartan Hughes
Declan Lonergan
Cathal O'Donnell
Valerie Small
John O'Donnell
Sean Walsh
Gerald Kerr
Stephen Cusack
Mark Doyle
Peter O'Connor

Present

Geoff King (Director)
Brian Power
Deirdre Borland
Adrian Murphy
Ronan O'Sullivan

Apologies

Lawrence Kenna
David Menzies
Frank O'Malley

1. Chair's business

The Chair welcomed the assembled members to the meeting. She advised the group that she and the Director will meet with a representative from the ICGP to develop a link with MAG and PHECC.

The Chair acknowledged the support demonstrated from MAG and PHECC during her recent bereavement.

Valerie Small thanked the group for feedback received regarding the Emergency Medicine Programme Ambulance Handover SOP. She committed to keep the group informed of developments with the SOP.

The Director reminded the group that the ICEM conference will be held in June. Ronan O'Sullivan offered 20 reduced price places to MAG members and their organisations at a pre-conference workshop entitled Pre-Hospital Research – FALCK Foundation. The Director thanked him for this offer and advised the members present to communicate with Deirdre Borland should they wish to take up this offer.

The Chair formally congratulated Niamh Collins on her appointment to the position of Consultant in Emergency Medicine at Connolly Hospital.

2. Minutes

Resolution: That the minutes from the Medical Advisory Group meeting held on the 26th April 2012 be agreed.

Proposed: Macartan Hughes

Seconded: Niamh Collins

Carried without dissent

2.1 Matters arising

Mark Doyle expressed a concern that the mapped timelines published by the ACS Programme are not achievable. Test runs have been carried out within the Waterford area which demonstrated that the timelines are not accurate. The Director suggested he communicate his concerns officially with the ACS Programme.

Brian Power asked Sean Walsh for his opinion regarding a request to make Ondansetron available for administration to paediatric patients for nausea and vomiting particular during long transfer times. Sean indicated that as the medication is currently use in hospital is relatively limited for nausea and vomiting he could not recommend that it be used in a pre-hospital setting for this indication without further evidence and research.

Martin O'Reilly asked if there was any update from the End of Life forum regarding do not resuscitate issues in pre-hospital settings. He asked that this be looked at urgently as it is posing a difficulty for practitioners; he cited getting approximately two calls per week from practitioners seeking guidance.

Discussion ensued on the End of Life Forum. It was felt that the issue raised should be addressed through that forum.

3. Update on Fentanyl Project

Dr. Adrian Murphy and Prof. Ronan O'Sullivan were invited to the meeting to give a presentation on the development of the Fentanyl project to the MAG. The project arose out of a knowledge gap regarding the pre-hospital administration of analgesics to paediatric patients, particularly pre verbal children. Adrian Murphy informed the group that the study is currently live in 7 emergency Departments with every child under 16 being targeted. A focus of the research is the effectiveness of Intranasal Fentanyl.

Arian Murphy synopsized a 3 month interim report stating that currently there is scope to greatly improve how paediatric pain is assessed and treated. The Director thanked Adrian for his

presentation of the study and work undertaken thus far and welcomed further findings to aid the MAG improve CPGs for the treatment of pain in paediatric patients.

Declan Lonergan called for improvements as to how assessment of pain is taught to practitioners during their training. Paul Lambert echoed this and asked that paediatric EDs allow practitioners interaction with paediatric patients during clinical placements. Gerry Kerr cautioned against the total suppression of pain as it does provide a protective function. The Chair asked that the ICGP be informed as it would be helpful if GP practices be made aware of the project. Adrian Murphy agreed to liaise with her on this.

4. KPI Update

A report by Ronan O'Sullivan, Adrian Murphy and Abel Wakai was circulated for the group's attention. Ronan O'Sullivan gave a brief overview of the study protocol which is currently at the literature review stage. They hope to identify potential KPIs and seek feedback and develop suggestions. He agreed to submit a proposal for funding to the Director within one month. Mark Doyle agreed to take the lead and determine the suitability of the proposal and report back to MAG.

5. CPGS

Brian Power introduced a suite of new treat and referral CPGs for initial feedback. These included exclusion criteria for entry to the treat and refer process. A discussion ensued regarding the practicalities of implementing a treat and refer process. Brian also informed the group that he is undertaking a PhD with treat and referral as his area of interest. Gerry Bury confirmed that he is acting as Brian's PhD supervisor.

Macartan Hughes asked the group to be cognisant regarding the training hours involved in implementing these CPGs.

Cathal O'Donnell stressed the importance of having a functioning Clinical Audit and Clinical Supervision system in place.

Gerry Bury cautioned that consideration be given to how such a process could potentially affect 999 calls and low acuity cases. He said that the dispatchers could have an important role in determining when an emergency vehicle should be dispatched. The Director informed him that the EMS Priority Dispatch group are currently investigating this.

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Stephen Cusack asked that it not be forgotten that it is still the Emergency Departments duty to evolve to cater for all presenting patients rather than relying on other services to deflect certain cases.

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Each of the CPGs agreed to proceed with development were then reviewed for initial feedback.

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Stephen Cusack asked for the title to be changed to toothache. Niamh Collins asked that inability to open mouth fully be added to exclusion box. Mark Doyle questioned the appropriateness on the 48hr pathway.

- *Minor Burn Treat and Refer CPG*

Mark Doyle asked that non solar be added to the exclusion box after radiation burn.

6. AOB

The Chair thanked the group for their input and welcomed the excellent attendance to the meeting. The next meeting was scheduled for June 21st. There being no other business the meeting was ended.

Signed: _____

Date: _____

The Medical Advisory Group

Meeting Minutes 21st June 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Niamh Collins
Macartan Hughes
Peter O'Connor
Declan Lonergan
Cathal O'Donnell
Brendan Whelan

Present

Geoff King (Director)
Brian Power
Deirdre Borland

Apologies

Lawrence Kenna
David Menzies
Frank O'Malley
Sean Walsh
Gerry Kerr
John O'Donnell
Martin O'Reilly
Mark Doyle
Paul Lambert
David Janes
Stephen Cusack
Valerie Small

1. Chair's business

The Chair welcomed the assembled members to the meeting.

The Director outlined that as Council's term of office is due to expire later in the month, he will make efforts to ensure the work of committees can continue until such time as a new Council is (re)appointed. He undertook to keep MAG informed of any developments in this regard.

2. Minutes

Resolution: That the minutes from the Medical Advisory Group meeting held on the 31st May 2012 be agreed.

Proposed: Macartan Hughes

Seconded: Declan Lonergan

Carried without dissent

3. KPI Update

The Director informed the group that indicative costings have been provided to the PHECC office. He has scheduled to meet with Mark Doyle, Abel Waiki and Ronan O'Sullivan to discuss the development of the KPI project. Zelie Gaffney asked that a GP representative be included in this project.

4. CPGS

An updated Delphi feedback report was circulated by Brian Power. This included feedback that was sent in after the distribution of the meeting papers.

4.1 Clinical Care Pathway Decision – Treat & Referral

Declan Lonergan asked if the treat & refer project should be piloted with AP practitioners only. Cathal O'Donnell disagreed stating that this may push AP's towards low acuity calls. The Director stated that CPGs were chosen as low risk, and the paramedics should be given the opportunity to partake in the programme.

Macartan Hughes asked if it would be possible to run two pilots in different regions involving both P's and AP's. Cathal O'Donnell agreed with this suggestion provided it benefited from the support of a clinical supervisor. He also asked that clarification be given regarding the term responsible adult rather than legal guardian.

It was suggested that the term an "adult who is both capable and willing to take responsibility of the patient" may suffice. This should be applied across all treat and refer CPGs.

Niamh Collins asked that there be more structure given to the exclusion categories.

Lawrence Kenna (in absentia) questioned the reasoning behind listing serious life threatening conditions such as stroke after stating that only non serious or non life threatening conditions be considered.

Macartan Hughes agreed stating that he would be happier for no conditions to be listed.

Niamh Collins suggested to change to inclusion criteria instead of exclusion criteria and offered the following inclusion criteria:

- Age >18
- Reliable History
- Good social support
- Demonstrates capacity and willingness to engage
- Vital signs inside normal range following care
- Compliant with treatment including own medication
- Non serious non life threatening, after treatment
- *Pregnancy be specified as a specific exclusion

It was agreed to change to inclusion criteria and accept the list proposed by Niamh Collins. It was also agreed to change "responsible adult" to "an adult both capable and willing to accept responsibility". This term will be used throughout all Treat and Refer CPGs.

Resolution: That the Medical Advisory Group recommend to Council CPG Clinical Care Pathway Decision –Treat & Referral for approval subject to the changes agreed

Proposed: Peter O'Connor

Seconded: Cathal O'Donnell

Carried without dissent

4.2 Hypoglycaemia –Treat & Referral

Paul Lambert (in absentia) asked that “if yes” to any of the Clinical care pathway selection; that the CP2 option be removed and transport to ED be indicated. This was agreed.

Macartan Hughes asked for clarification regarding administering 10% dextrose to a patient and then not transporting them. He also asked that the group consider changing the indicated level of glucose to 5 mmol/L rather than 4.5 mmol/L to cater for the +/-1 mmol/L error range on the glucometer. The Chair asked if stating the limit to be 4 mmol/L would be better for consistence with the clinical pathway. Niamh Collins clarified that a 10 mL flush should be given after dextrose infusion. She also asked that first ever hypoglycemic event be part of the exclusion criteria, and that a serial improvement of blood glucose levels should be required prior to a referral clinical pathway. Niamh Collins suggestions were agreed. The < 4 mmol/L glucose level was agreed as an exclusion criteria as was the removal of the reference to higher glucose level for CP3.

Resolution: That the Medical Advisory Group recommend to Council CPG Hypoglycaemia – Treat & Referral for approval subject to the changes agreed.

Proposed: Niamh Collins

Seconded: Macartan Hughes

Carried without dissent

4.3 Isolated seizure –Treat & Referral

Cathal O'Donnell asked if a prompt to check blood sugar was required.

Niamh Collins asked that the glucose range is amended to <4 mmol/L and temperature abnormal be included as exclusion criteria. Both of these suggestions were agreed.

Resolution: That the Medical Advisory Group recommend to Council CPG Isolated seizure – Treat & Referral for approval subject to the changes agreed.

Proposed: Peter O'Conner

Seconded: Cathal O'Donnell

Carried without dissent

4.4 Epistaxis –Treat & Referral

Paul Lambert and Martin O'Reilly (in absentia) asked that the CP2 route be removed. This was not agreed.

The Chair suggest amending the age limit to > 60 for CP2 and adding history of hypertension to the exclusion box.

It was agreed that a history of hypertension or BP \geq 140/90 be moved to the exclusion criteria, and the age limit of > 60 be included for CP2 pathway.

Resolution: That the Medical Advisory Group recommends to Council CPG Epistaxis –Treat & Referral for approval subject to the changes agreed.

Proposed: Brendan Whelan

Seconded: Niamh Collins

Carried without dissent

4.5 Oleoresin Capsicum (pepper) Spray – Treat & Referral

Brendan Whelan asked that short of breath be changed to shortness of breath, this was agreed.

Resolution: That the Medical Advisory Group recommends to Council CPG- Oleoresin Capsicum (pepper) Spray – Treat & Referral for approval subject to the changes agreed.

Proposed: Macartan Hughes

Seconded: Peter O'Connor

Carried without dissent

4.6 Toothache – Treat & Referral

Niamh Collins asked that an exclusion criteria of normal speech and swallowing and mouth open with no drooling be added. Macartan Hughes asked that no relief with analgesia to specify PO analgesia. Both of these suggestions were agreed.

Resolution: That the Medical Advisory Group recommends to Council CPG Toothache – Treat & Referral for approval subject to the changes agreed.

Proposed: Declan Lonergan

Seconded: Peter O'Connor

Carried without dissent

4.7 Minor Burns – Treat & Referral

Niamh Collins asked that it be specified that anyone with a burn injury should be advised to seek medical advice within 48 hours as Paramedics may not have sufficient exposure or experience of recognising the various severity of burns. As a result it was agreed to remove CP4 as a clinical care pathway. In light of the minor nature of sunburn Cathal O'Donnell suggested that "except sunburn" be added after > 1% surface area in the exclusion criteria. This was agreed.

Resolution: That the Medical Advisory Group recommends to Council CPG Minor Burns – Treat & Referral for approval subject to the changes agreed.

Proposed: Niamh Collins **Seconded:** Declan Lonergan

Carried without dissent

5. Registrant Queries

5.1 Pyrexia

An email was which was received from an AP requesting the group to discuss the feasibility of permitting paramedics to administering paracetamol of pyrexia was discussed.

Cathal O'Donnell suggested for temperature of 38°C or higher paracetamol should be administered by EMTs, Paramedics and Advanced Paramedics.

Resolution: That the Medical Advisory Group recommends the developments/updating of a CPG to enable the administration of paracetamol to pyrexial patients with a temperature of $\geq 38^{\circ}\text{C}$.

Proposed: Cathal O'Donnell **Seconded:** Peter O'Connor

Carried without dissent

5.2 IM administration of Ondansetron and Cyclizine.

An email which was received from an AP requesting the group to discuss the feasibility of permitting practitioners to administer Ondansetron or Cyclizine IM where IV access is unavailable.

The Chair asked that if agreed ACS patients and those on anticoagulant/antiplatelet therapy be excluded.

Brian Power pointed out that currently, this is not permissible under the Medicinal Products Schedule 7 but that it has been included for updating if the new schedule

Resolution: That the Medical Advisory Group recommends that when the Medicinal Products Schedule is updated the CPGs are amended to enable the administration of Ondansetron or Cyclizine IM where IV access is unavailable, subject to the exclusion of ACS patients and those on anticoagulant/antiplatelet therapy.

Proposed: Peter O'Connor **Seconded:** Declan Lonergan

Carried without dissent

6. AOB

Cathal O'Donnell asked that the administration of Amiodarone for Ventricular tachycardia post ROSC be included on the agenda of the next meeting.

The Chair thanked the group for their input. The next meeting was scheduled for Sept 27th.

There being no other business the meeting was ended.

Signed: _____

Date: _____

The Medical Advisory Group

Meeting Minutes 27th September 2012, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Niamh Collins
Macartan Hughes
Sean Walsh
Gerry Kerr
Declan Lonergan
Cathal O'Donnell
John O'Donnell
Brendan Whelan
John O'Donnell
Mark Doyle
Stephen Cusack
Valerie Small

Present

Geoff King (Director)
Brian Power
Anne Keogh

Apologies

Lawrence Kenna
David Menzies
Frank O'Malley
Martin O'Reilly
Paul Lambert
David Janes

1. Chair's business

The Chair welcomed the assembled members to the meeting. The Chair introduced new member; Dr Seamus Clarke as representative from the ICGP. The Chair suggested that consideration be given to inviting an Anaesthetic representative to MAG.

The Director outlined that the Council's term of office has expired. The Department have not yet appointed a new Council. Before Council expired they put in place a mechanism to ensure the continuing functions of PHECC.

2. Minutes

Resolution: That the minutes from the Medical Advisory Group meeting held on the 21st of June 2012 be agreed.

Proposed: Niamh Collins

Seconded: Brendan Whelan

Carried without dissent

3. KPI Update

The Director informed the group that Mark Doyle, Ronan O'Sullivan, Adrian Murphy and Abel Waiki were developing measurable KPIs. The Director indicated that they will be ready for the first quarter of 2013. There was discussion on the background on the time based KPIs and the letter sent to HIQA from Council.

4. CPGS

4.1 Treat & Referral; patient information sheets.

As part of the Treat & Referral project, Brian Power introduced patient information sheets. These sheets were drafted to ensure that patients who were not transported to ED had appropriate information available following the departure of the paramedic. They were drafted in the format of the CARE programme of the NSW Ambulance Service. The information sheets may need to be amended to suit the Irish situation.

It was suggested that the scheme be piloted in an area. Valerie Small advised that a percentage of the population do not have a GP. It was suggested that all sheets be passed by the Health Literacy Group and also be in 'plain English'.

Gerry Bury stated that treat & refer will result in major parts of the health system interfacing. That there will be a need for much testing and trailing. There is also a need for systems to integrate with each other.

4.1.1 Low blood sugar (Hypoglycaemia) information sheet.

Seamus Clarke expressed concern that the wording would lead patients to expect a specific clinical intervention i.e. 'full medical check-up' when it may not be required. He suggested more generic information could be given which would not appear to dictate what the GP would provide. Seamus also had an issue with the 48 hour period as it may not be possible over a weekend.

Niamh Collins suggested that the box at the end of the information sheet was too general with reference to 'if your symptoms worsen'. It was recommended that specific symptoms should be listed to ensure that patients understood exactly what may be of concern. It was recommended that this change be reflected on all information sheets. The term 'specialist' was also considered too generic and perhaps should have options that reflect the services locally for diabetic patients. It was suggested that the HSE Diabetic Programme be consulted.

4.1.2 Isolated seizure information sheet.

Similar issues were identified on this information sheet to the hypoglycaemia sheet. It was recommended that an additional point, 'Eat properly' be added to the 'what to do after the paramedic has left' section.

4.1.3 Nose bleed (Epistaxis) information sheet.

Similar issues were identified on this information sheet to the hypoglycaemia sheet. It was recommended that an additional point, 'very hot or cold food or drink' be added to the 'what to avoid' section. The wording in relation to patients older than 60 years be replaced with 'We advise you to make contact with your GP or GP out of hours service'.

4.1.4 Toothache information sheet

Similar issues were identified on this information sheet to the hypoglycaemia sheet. Niamh Collins was concerned that if a patient had an abscess that they may need to get antibiotics as soon as possible. It was recommended that the sentence relating to antibiotics be deleted. It was suggested that the Dental association or should we contact Siobhan Doherty chief dental officer for Kildare be consulted.

4.1.5 Minor burns information sheet

Similar issues were identified on this information sheet to the hypoglycaemia sheet. Niamh Collins asked that it be specified that anyone with a burn injury should be advised to seek medical advice within 48 hours. There was much discussion as to severity of burns and the ability to assess the depth of a burn. Gerry Bury indicated that there is no such thing as a minor burn and the advice would be to contact a medical practitioner for assessment of healing within 2 to 3 days. It was recommended that the reference to wound healing within two weeks is deleted. It was also suggested that a new sentence be added; 'Your burn should be reviewed by a medical practitioner within two to three days'. Typo, reference to dentist be removed.

4.1.6 Pepper spray information sheet.

Similar issues were identified on this information sheet to the hypoglycaemia sheet. It was recommended that reference to cleaning contact lenses is removed and the patient should be advised to dispose of contact lenses that have been contaminated.

4.1(a) Treat & Referral CPGs

Even though much of the discussion on the information sheets and the corresponding CPG was completed in parallel they are presented separately in the minutes for clarification on the changes agreed.

4.1(a) 1 Clinical Care Pathway Decision – Treat & Referral

A number of amendments were recommended;

- (i) An upper age of 60 be included in the generic patient inclusion criteria

- (ii) An additional inclusion criteria 'Absence of self-inflicted injury or assault' be added.
- (iii) Replace 'must' with 'should' in relation to practitioner transporting to ED
- (iv) Add 'carer' after 'adult' in the capable & willing decision box.
- (v) Change CP2 to 'follow up care within two hours'
- (vi) Add 'arranged with local practitioner' after CP2
- (vii) Add 'as soon as practicable to CP3
- (viii) Change Systolic BP to '111 – 150' in vital signs box

4.1(a) 2 Hypoglycaemia –Treat & Referral

Sean Walsh expressed concern that a patient would not be transported to ED following IV glucose. A discussion ensued on the risk of such action. Brian Power agreed to come back to the meeting with information from services that have a treat & referral protocol in place and also papers to support the safety of this process. It was agreed to look at the Diabetic Programme and the CPG and the information sheet be amended to comply with their best practice recommendations.

A number of amendments were recommended;

- (i) Add to specific exclusion criteria 'Recent medication change or additional medications (within 30 days)
- (ii) Add to specific exclusion criteria 'Patient not registered with a GP practice'
- (iii) To reinforce the exclusions, change wording from 'if in doubt about specific hypoglycaemic exclusions etc.' to 'if in doubt about 1 to 9 above etc.'
- (iv) Replace 'must' with 'should' in relation to practitioner transporting to ED.
- (v) Add text box 'ensure that the patient takes in calories'

4.1(a) 3 Isolated seizure –Treat & Referral

It was agreed to look at the Epilepsy Programme and the CPG and the information sheet be amended to comply with their best practice recommendations.

A number of amendments were recommended;

- (i) Change 'Absence of specific exclusions' to Exclusions present'. It was further recommended that this be changed on all the T&R CPGs.
- (ii) In the specific exclusions; move 'first seizure' to top of the list
- (iii) In the specific exclusions; change 'traumatic brain injury' to 'head injury'
- (iv) In the specific exclusions; add additional criterion 'Recent medication change or additional medications (within 30 days)'.

- (v) In the specific exclusions; add additional criterion, 'Not registered with a GP'
- (vi) Add a text box describing a isolated seizure.

4.1(a) 4 Epistaxis –Treat & Referral

A discussion took place on the compatibility between the CPG and the 'Nightingale software' used by GP co-ops. Concern was expressed that both should not end up with different pathways if a patient was triaged by both.

A number of amendments were recommended;

- (i) Change 'Absence of specific exclusions' to Exclusions present'.
- (ii) In the specific exclusions; add additional criterion, 'Not registered with a GP'
- (iii) As > 60 years has been added as a generic exclusion this makes the clinical care pathway P2 for this CPG redundant.

4.1(a) 5 Toothache – Treat & Referral

A discussion took place on the role of a GP, in the absence of a Dentist, for toothache.

A number of amendments were recommended;

- (i) Change 'Absence of specific exclusions' to Exclusions present'.
- (ii) In the specific exclusions; add additional criterion, 'Not registered with a GP'
- (iii) As Dentists do not generally have out of hours services the clinical care pathway P2 for this CPG is redundant.

4.1(a) 6 Minor Burns – Treat & Referral

There was a debate on the term non-accidental injury. Sean Walsh expressed the view that it related specifically to paediatrics and should not be used in a generic sense. A typo was identified 'lighting' for 'lightning'.

A number of amendments were recommended;

- (i) Change 'Absence of specific exclusions' to Exclusions present'.
- (ii) In the specific exclusions; add additional criterion, 'Not registered with a GP'
- (iii) Change 'non-accidental injury' to 'intentional injury'.

4.1(a) 7 Oleoresin Capsicum (pepper) Spray – Treat & Referral

Brendan Whelan asked that of shortness breath be changed to short of breath.

A number of amendments were recommended;

- (i) Change 'Absence of specific exclusions' to Exclusions present'.
- (ii) Change 'shortness breath' to 'short of breath'.

As there was an urgency on the resolution of the handover of ambulance patients in emergency departments, this item was discussed next from the agenda.

5. Patient handover in EDs

Niamh Collins outlined the programme that is being developed and being rolled out nationally. It will consist of 15-20 minute e-learning programme and a DVD. PHECC are funding the training package. It is envisioned that 1,800 – Doctors, Nurses and Clerical staff would undertake the DVD part of the training.

Niamh Collins gave some background information on how the Emergency Medicine Programme, the Pre-Hospital Emergency Care Council and the National Ambulance Service all had an input into the handover in ED project.

Geoff King gave some background on PHECC's involvement. Geoff King stated he had recently had communications from Ray Carney, representing the joint voluntary ambulance service, in relation to issues that the Voluntary ambulance services were having. They wish to be included in the process. He stated also that this project had to be cognisant of the Private, Voluntary and Auxiliary agencies also. Geoff also stated that the voluntary ambulance services were increasingly opting out of communicating with HSE control centres as they are being put through the AMPDS systems when they ring to inform the HSE of a patient being transported from an event. It was stated that this particular issue is probably a matter for the EMS Priority Dispatch Sub Group initially.

Sean Walsh queried why ISBAR was not used as the communication mnemonic as it is now standard in hospitals and that it may cause confusion for two different ones to be used by the same medical and nursing staff.

Mark Doyle expressed concern that the hand over and the pre-alert protocols were interwoven into the same policy where as they are separate entities. It was also stated that the pre-alert protocol was not presented for the meeting and could not be discussed fully. There was general agreement that a pre-alert protocol would be welcome. After much discussion on Pre-alert protocol – it was decided that this would need more work and would be revisited at the next meeting.

A number of amendments were recommended;

- (i) Delete 'including but not limited to pre-alert notification' in the **Purpose** paragraph.
- (ii) Delete 1.4 from **1 Preparation**.
- (iii) Move 1.3 in **1 Preparation** to end of 1.5

- (iv) Add 'when possible' to the end of the text in 1.8.
- (v) Delete 6.3 in **6 Governance**.

Resolution: That the Medical Advisory Group approves the 'Handover of Ambulance Patients in Emergency Departments' document subject to the amendments listed above and recommends the I MIST AMBO mnemonic be used to compose a standard report for patient handover at EDs by pre-hospital emergency care practitioners.

Proposed: Cathal O'Donnell **Seconded:** John O'Donnell

Carried without dissent

6. AOB

Cathal O'Donnell informed the group the STEMI was being rolled out in the west on Monday 1st October and country wide by the end of the month.

He also requested that the administration of Amiodarone for Ventricular tachycardia post ROSC be included on the agenda of the next meeting.

The Chair thanked the group for their input. The next meeting was scheduled for October 25th at the PHECC offices.

There being no other business the meeting closed.

Signed: _____

Date: _____

The Medical Advisory Group
Meeting Minutes 25th October 2012, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Niamh Collins
Macartan Hughes
Sean Walsh
Sean O'Rourke
Gerry Bury
Declan Lonergan
Mark Doyle
Paul Lambert

Present

Geoff King (Director)
Brian Power
Anne Keogh

Apologies

Lawrence Kenna
David Menzies
Frank O'Malley
Gerry Kerr
Martin O'Reilly
David Janes
Stephen Cusack
Valerie Small
Conor Egleston
Peter O'Connor
David McManus
Seamus Clarke
Brendan Whelan
John O'Donnell
Cathal O'Donnell

Chair's business

The Chair welcomed the assembled members to the meeting and acknowledged apologies from absent members. The Chair asked that all members be notified of the next MAG meeting on Thursday 29th November, at 10:00am as this will be the last MAG meeting for 2012. The Chair complimented MAG and PHECC on the article in the PHECC Voice on medications administered.

2. Minutes

Resolution: That the minutes from the Medical Advisory Group meeting held on the 27th September 2012 be agreed.

Proposed: Macartan Hughes

Seconded: Sean Walsh

Carried without dissent

3. KPI Update

Mark Doyle informed the group that a KPI teleconference had taken place. HIQA had initially stated 8 headings with a number of items under the 8. The group plan to circulate 3 stage process by Delphi through e-mail, the 1st next month, the 2nd in early new year and finishing in March. The plan is to have approximately 100 people in the Delphi Panel. There is a need to identify experts from the various areas to answer the potential KPI topics. The Medical Director of NAS to propose names from HSE National Ambulance Service Officers. There is a need for a lot of clinical expertise Paramedics, Advanced Paramedics, Education and Competency Assurance Team (ECAT), Medical Directors, Medical Advisor and other areas i.e. safety, fleet and logistics. A list of competencies that will be required on the panel will be compiled by Adrian Murphy. 50% to be clinically active (some Paramedics and Advanced Paramedics can have dual roles clinical and administrative) and 50% mix of other. Gerry Bury recommended that there be GP representation on the panel. Paul Lambert asked can more weight be put on answers of experts. Mark Doyle advised that there are a lot of items on the list that are just statements. There needs to be a standard set for each one. Gerry Bury stated that the indicators are good and asked if MAG had any input. Can MAG process concerns that expenditure and cost versus value are not compatible with clinical indicators and clinical impact and outcomes. The logic must change if you are monitoring the spend per patient. There was discussion as to the relevancy of the KPIs. Mark Doyle stated that HIQA were happy with the process and they see their role as monitoring not dictating. Niamh Collins suggested that if certain KPIs were seen as not important they should be removed. Mark Doyle confirmed that the KPIs can change. Sean Walsh asked if Council recommend Clinical Care KPIs could they be put in place. Sean Walsh also raised the point of a HRB Grant being applied for in relation to the KPI development.

4. CPGS

4.1 Treat & Referral Information sheets

Brian Power informed the group of feedback received on the treat and referral CPGs. The Dental Council is reviewing the toothache CPG, the Garda Medical Officer is reviewing the pepper spray CPG, the HSE Diabetes Programme and the HSE Epilepsy Programme are reviewing the respective information sheets and CPGs.

Gerry Bury advised that if the clinical issue re-emerged then the first port of call should be 999 and not the GP. It was agreed to reverse the order in the final information box on all information sheets to 999 first.

Several changes were recommended on the nose bleed information sheet;

- a) Replace 'How to stop the bleeding' with 'If the bleeding reoccurs'
- b) Delete reference to ice packs
- c) Make new bullet point with last sentence in 'if the bleeding reoccurs' section.

Following suggestions it was agreed to ensure that each sheet is subject to 'Plain English' testing to avoid any misinterpretation by the non-clinically trained lay public.

Resolution: That the Medical Advisory Group recommends to Council Treat & Referral patient information sheets for approval subject to the changes agreed.

Proposed: Sean O'Rourke

Seconded: Paul Lambert

Carried without dissent

4.2 Treat & referral CPG

Following discussion on the treat & referral CPGs the following changes were agreed;

Clinical Care Pathway Decision – Treat & Referral

Add the following to the generic patient inclusion criteria

- Absence of significant relevant co-morbidity.
- 1st call for same condition within 30 days.
- Must be registered with a general practitioner.

As 'must be registered with a general practitioner' is now an inclusion criterion, it should be removed from the exclusion criteria on the individual treat & referral CPGs.

Epistaxis – Treat & Referral

- Replace 'unable to stop haemorrhage despite 15 minutes of nares compression' with 'active bleeding despite 15 minutes of active care.'
- Add 'bleeding disorders' as a generic exclusion.

Toothache – Treat & Referral

- Replace 'Myocardial Infarction' with 'ACS'

Gerry Bury suggested that a more update reference should be sought for the Epistaxis – Treat & Referral CPG.

Resolution: That the Medical Advisory Group recommends to Council the Treat and Referral CPGs for approval subject to the changes agreed.

Proposed: Declan Lonergan

Seconded: Macartan Hughes

Carried without dissent

Mark Doyle cautioned that there is some confusion in the service as to the project, some paramedics are suggesting that Treat & Referral has been introduced and they are authorised to implement same. Gerry Bury stated that practitioners need to understand treat and refer is only in testing stage and not approved for roll out at this time. It was agreed that this project be piloted in a specific areas in a controlled fashion and carried out by specifically trained personnel. Macartan Hughes suggested that the Medical Director of NAS issue an advisory note to staff on Treat & Referral CPGs.

4.3 Review of CPGs

Brian Power advised the group that as part of the PHECC KPIs a review of CPG is to take place every three years. The CPGs to be review were circulated to MAG members, with each receiving two to three CPGs each. Feedback from reviewers was included in the meeting papers.

4.3.1 CPG 5/6.5.6 Breech Birth; Reviewed by Zelig Gaffney. It was decided to change 'Oxygen Therapy' to consider 'Oxygen Therapy'

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 5/6.5.6 Breech Birth as agreed.

Proposed: Niamh Collins

Seconded: Macartan Hughes

Carried without dissent

4.3.2 CPG 4/5/6.4.25 Epistaxis; Reviewed by Valerie Small. It was decided to change 'digital pressure for 3-5 minutes' to 'digital pressure for 15 minutes'.

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 4/5/6.4.25 Epistaxis as agreed.

Proposed: Niamh Collins

Seconded: Macartan Hughes

Carried without dissent

4.3.3 CPG 5/6.3.3 Exacerbation of COPD; Reviewed by Mark Doyle. It was suggested to make Ipratropium a Paramedic medication, to give routinely in COPD and severe asthma. Remove parenteral steroids and give steroids in severe asthma but remove from COPD. It was suggested by Gerry Bury to insert a red box on to the CPG to administer Hydrocortisone even if already on oral or inhaled steroids. There was much further discussion in relation to O₂ administration and Niamh Collins asked if the COPD care programmes could be consulted. Sean O'Rourke raised the issue of confusion between bronchospasm and Asthma. Niamh Collins asked could the evidence data be requested from Limerick CPR in relation to heart failure.

4.3.4 CPG 4.3.3 Exacerbation of COPD; Reviewed by Conor Egleston. It was suggested that the Asthma care programmes could be referenced. Salbutamol should be administered by EMTs for Exacerbation of COPD.

Gerry Bury suggested that labeling and problem solving tools were inconsistent. Brian Power stated that he would review and bring back to MAG.

4.3.5 CPG 6.4.5 Foreign Body Airway Obstruction – Adult; Reviewed by Martin O'Reilly. Add box 'consider waveform capnography post ET intubation'

Macartan Hughes stated that Cathal O'Donnell would issue an interim directive for continuous monitoring of CO₂.

Resolution: That the Medical Advisory Group recommends to Council the changes on CPG 6.4.5 Foreign Body Airway Obstruction – Adult as agreed.

Proposed: Niamh Collins

Seconded: Macartan Hughes

Carried without dissent

4.3.6 CPG 6.4.24 Hypothermia; Reviewed by Stephen Cusack. It was recommended to move the monitor box above the primary survey box, this was rejected. Hypothermia is defined as < 35°C, adjust the figures to reflect this on the CPG. Discussion about warmed O₂ took place and it was decided to remove O₂. It was agreed that paramedic level should be included on this CPG. The fluid volume for warmed fluids for paediatric patients to be

reduced to 10 mL/Kg. Brian Power to check fluid volume for adults with 2010 ILCOR guidelines.

4.3.7 CPG 4/5.4.24 Hypothermia; Reviewed by Stephen Cusack. It was recommended to move the monitor box above the primary survey box, this was rejected. Hypothermia is defined as $< 35^{\circ}\text{C}$, adjust the figures to reflect this on the CPG. Discussion about warmed O_2 took place and it was decided to remove O_2 . It was agreed that paramedic level should be removed from this CPG.

Resolution: That the Medical Advisory Group recommends to Council to amend CPG 4/5.4.24 Hypothermia as agreed.

Proposed: Gerry Bury

Seconded: Declan Lonergan

Carried without dissent

4.3.8 CPG 5/6.3.2 Inadequate Respirations - Adult; Reviewed by Mark Doyle. It was recommended to make ipratropium bromide a paramedic medication which should be administered routinely in COPD and severe asthma. Steroids should be considered. For Magnesium Sulphate add to consider 'if asthmatic'. GTN and Furosemide should not be administered in the presence of pneumonia. Gerry Bury expressed concern about the use of Furosemide in this setting. Macartan Hughes suggested that it was timely to introduce CPAP.

4.3.9 CPG 3.3.2 Inadequate Respirations - Adult; Reviewed by Conor Egleston. It was suggested that the Asthma care programmes could be referenced.

4.3.10 CPG 5/6.7.5 Inadequate Respirations - Paediatric; Reviewed by Sean Walsh. The dose of Salbutamol via aerosol is too low. For mild and moderate cases by spacer the dose should be 6 puffs if < 6 years and 12 puffs if > 6 years old. If Ipratropium is given for moderate cases by spacer it should be 4 puffs if < 6 and 8 puffs for > 6 years old.

It was agreed that all the inadequate respiration CPGs be updated, taking into account the comments and suggestions and presented back to MAG.

4.3.11 CPG 4.7.13 Shock from Blood Loss - Paediatric; Reviewed by Niamh Collins. To ensure consistency in language change "Shock" to "Signs of inadequate perfusion" as the entry point. List the order of signs of inadequate perfusion - generally either an ABC or "Hands, Head & Neck, Chest, Abdo, Legs & Back" approach. Add a text box on patient positioning 'lie patient flat with legs elevated if safe to do so'.

Resolution: That the Medical Advisory Group recommends to Council to amend CPG 4.7.13 Shock from Blood Loss - Paediatric as agreed.

Proposed: Paul Lambert

Seconded: Zelic Gaffney

Carried without dissent

4.3.12 CPG 4.7.15 Spinal Immobilisation - Paediatric; Reviewed by Lawrence Kenna. There are no specific criteria for an EMT when considering a paramedic. It was agreed that 'consider paramedic' would be changed to 'notify a paramedic, advanced paramedic or doctor'

Resolution: That the Medical Advisory Group recommends to Council to amend CPG 4.7.15 Spinal Immobilisation - Paediatric as agreed.

Proposed: Mark Doyle

Seconded: Macartan Hughes

Carried without dissent

4.3.11 CPG 5/6.6.8 Crush Injury; Reviewed by Niamh Collins. Change the text box "Maintain AcBC" to include catastrophic haemorrhage. It was agreed not to change this CPG.

5. Queries re CPGs and Medications

5.1 Fentanyl research project; An e-mail from Dr Adrian Murphy in relation to the Fentanyl research project was tabled at the meeting. He made several suggestions for changes for the Pain Management CPGs which will Authorise Fentanyl administration.

- Pain Assessment
 - FLACC can be used in all children < 5 years
 - Wong Baker should be used in children 5-7 years
 - Analogue Pain Scale should be used in children > 8 years
- Intranasal Fentanyl should be administered to children > 1 year (not 6 months).
- Intranasal Fentanyl dosing frequency wording to specify "REPEAT ONCE ONLY - AT NOT LESS THAN 10 MINUTES AFTER INITIAL DOSE".

- Internationally accepted pain severity grading is Mild 1-3, Moderate 4-6, and Severe > 7.

Sean Walsh suggested taking the Wong Baker scale diagram off the CPG as FLACC was not there also.

Resolution: That the Medical Advisory Group recommends to Council to amend CPG 6.7.14S Pain Management – Paediatric and 6.2.6S Pain Management – Adolescent as recommended and to amend all other Pain Management CPGs to ensure consistency with the pain severity grading agreed.

Proposers: Macartan Hughes
Carried without dissent

Seconded: Zelic Gaffney

5.2 CPG 5/6.3.1 Advanced Airway Management – Adult.

David Menzies submitted a recommendation (included in the meeting papers) to update this CPG as there was a possibility of confusion in relation to the number of attempts at an advanced airway, in particular insertion of supraglottic airway after failed intubation. The updated version of the CPG as presented in the meeting papers was deemed to remove the confusion.

Resolution: That the Medical Advisory Group recommends to Council to amend CPG 5/6.3.1 Advanced Airway Management – Adult as agreed.

Proposer: Declan Lonergan
Carried without dissent.

Seconded: Paul Lambert

5.3 Local analgesia following IO access.

Michael Donnellan, AP, submitted a case study where IV access could not be gained on a diabetic patient with severe case of DKA. Medical oversight was sought and approval was given to insert an IO. When flushing the IO the patient indicated pain. The manufacturer recommends Lidocaine 2% is used to minimise the pain. Following a prolonged discussion it was decided that no decision could be made based on just one case and when more experience emerges that this issue will be given consideration again.

5.4 IV Paracetamol

Kevin Reddington, AP, submitted a case study where Morphine could not be administered to a patient in severe pain due to respiratory distress. He suggested a solution of using IV Paracetamol. Brian Power pointed out that IV Paracetamol is not currently on the Medicinal Products 7th schedule. Following discussion it was agreed that medical oversight could have authorised the administration of Morphine in the circumstances described.

6 Tactical Emergency Medical Services (TEMS)

Geoff King advised the group of a request from the Emergency Response Unit (ERU) of An Garda Síochána for advance clinical skills for ERU personnel involved in siege or other unsafe environments for practitioners to enter. The details were described in the meeting papers. There was concern about retired ERU Gardaí who might consider using these advanced clinical skills in other organisations. It was suggested that the licence only be available to the ERU members while serving in that capacity. There was concern also about 'Rambo' type courses being set up around the country by organisations other than An Garda Síochána and in particular without clinical governance. It was agreed that the situation needs to be well defined for TEMS practice to take place. The group gave support in principle to TEMS and the drafting of specific CPGs for this type of situation. Dr George Little, Consultant in Emergency Medicine, who has developed the TEMS programme, was requested to present to MAG at the next meeting.

7. AOB

The EMS Priority Dispatch Group brought their resolution on ProQA as outlined below to MAG for ratification;

- (i) ProQA 12.2 changes be introduced into the DCR table, and
- (ii) ProQA 12.2 pre-arrival instructions be adapted, and
- (iii) code 12 Alphas be upgraded to Bravo response, and
- (iv) code 17 and 30 alpha or omega involving fracture with gross deformity or open fracture be upgraded to Bravo response.

Resolution: That the Medical Advisory Group recommends to Council the DCR table with changes as advised.

Proposer: Paul Lambert

Seconded: Mark Doyle

Carried without dissent.

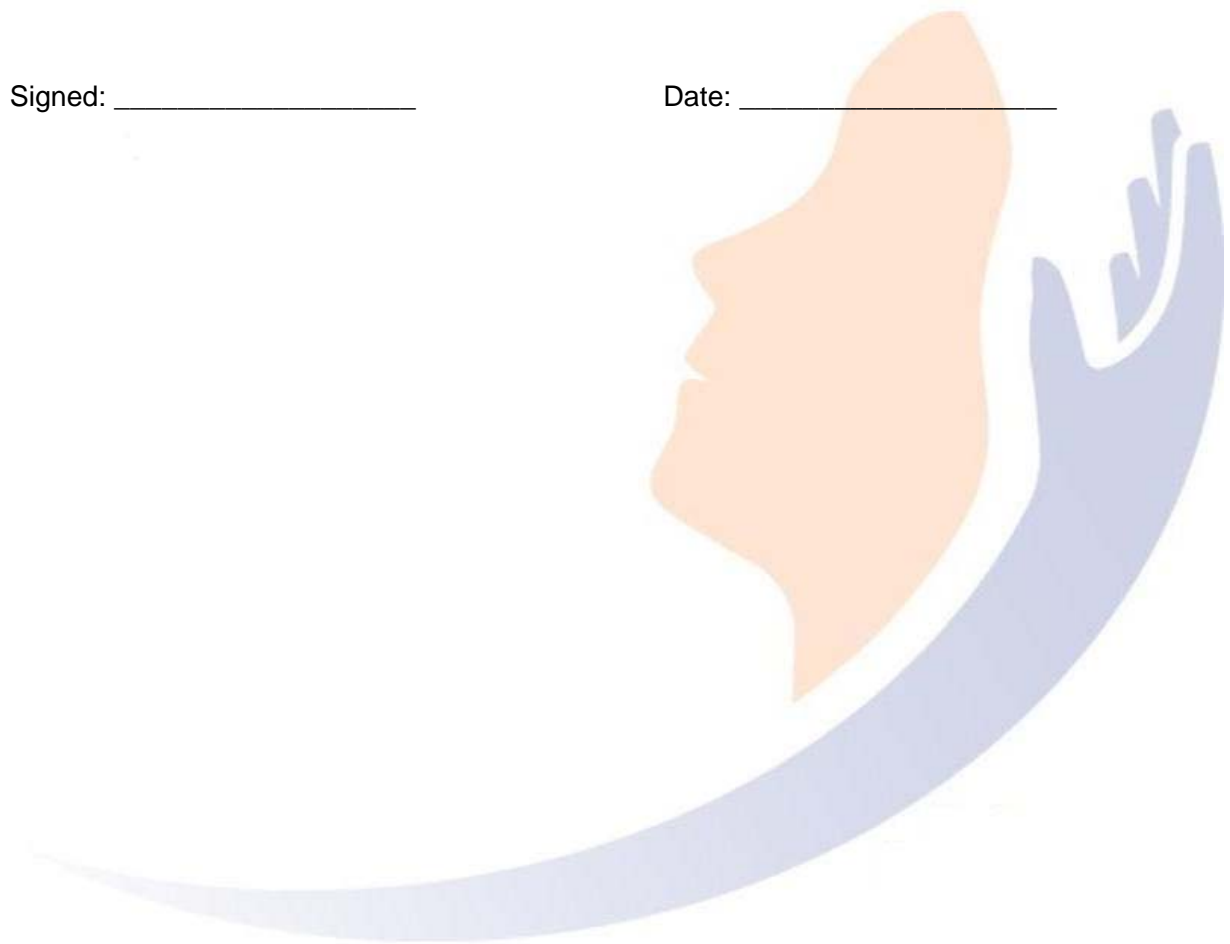
Niamh Collins suggested PHECC write to the Irish Medicines Board in relation to Mini Jets being without licence, to ask them to recommend a safe alternative. It was agreed that PHECC would write to IMB outlining this difficulty.

The Chair thanked the group for their input. The next meeting was scheduled for November 29th.

There being no other business the meeting was ended.

Signed: _____

Date: _____



The Medical Advisory Group

Minutes 24th February 2011, 10.30am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
John O'Donnell
Stephen Cusack
Niamh Collins
Mark Doyle
Sean Walsh
Valerie Small
Lawrence Kenna
Declan Lonergan
Macartan Hughes
Frank O' Malley
Cathal O' Donnell
Sean O' Rourke

Present

Geoff King (Director)
Brian Power
Shane Knox
Marion O' Malley

Apologies

Michael Garry
Brendan Whelan

1. Chair's Business

The Director opened the meeting by notifying the group of Council's appointment of Zelie Gaffney as Chair of the Medical Advisory Group. The Chair thanked the Council and acknowledged their support in her new role. The Chair then welcomed a new member, Sean O' Rourke, and advised the group of the resignation of Richard Lynch and George Little. Apologies were acknowledged.

The Director advised the group that there will be a review to the Medical Advisory Group membership and that a paper is currently being developed to go to Council. Suggestions for membership were previously put forward at the November 2010 meeting and the Director welcomed any further suggestions.

The Chair suggested that the meeting be concluded at 3pm and the Director advised the group that the AMPDS sub-group were meeting after the MAG, to consider further feedback relating the EMS Priority Dispatch Standard and DCR table. The standard has been approved and implemented but it seems there are nuances in the interpretation of wording and the group are going to revise the wording without affecting the standard already in place.

Resolution: That MAG give approval in principle for the AMPDS sub-group to revise the wording of the EMS Priority Dispatch Standard to clarify the issues identified.

Proposed: Cathal O’ Donnell
Carried without dissent

Seconded: Frank O’ Malley

The Chair continued the meeting by congratulating the out-going Chair, Cathal O’ Donnell, on his new appointment as Medical Director of the National Ambulance Service and stressed that the appointment is a very good development for pre-hospital emergency care.

Congratulations were also extended to Deirdre Borland on the birth of her baby boy.

The Chair commended Stephen Cusack and all emergency teams in their efforts following the recent plane crash at Cork Airport.

2. Minutes and Matters Arising

It was agreed that, due to the heavy workload, all items carried forward from the November MAG meeting, which were identified in agenda item no. 2 in the December meeting papers be addressed at a subsequent meeting. Agenda items 5, 6 & 7 from the December meeting will also be addressed at a later date.

Lawrence Kenna identified a typo on page 2 under item 2 – “expect” should read “except”.

Resolution: That the minutes from the Medical Advisory Group meeting of 16th December 2010 be approved.

Proposed: Niamh Collins
Carried without dissent

Seconded: Declan Lonergan

Brian Power identified two items which were addressed at the November meeting where a resolution was omitted from the minutes in error.

Brian Power sought a resolution to the discussion item regarding salbutamol for EMT’s. During the discussions it was agreed to remove the need for prescription first for salbutamol at EMT level. It was pointed out that this affected four CPGs: Inadequate Respirations – Adult, Inadequate Respirations – Paediatric, Allergic Reaction/Anaphylaxis – Adult and Allergic Reaction/Anaphylaxis – Paediatric.

Resolution: Remove the need for prescription first for use of salbutamol at EMT level and adjust the CPGs accordingly.

Proposed: Stephen Cusack
Carried without dissent

Seconded: Niamh Collins

At the November meeting it was agreed, for CFR Advanced level, to flag the authorisation to administer oxygen on the following CPGs:

- FBAO – Adult
- FBAO – Paediatric
- Cardiac Chest Pain - ACS
- Stroke

Resolution: To flag the authorisation for administration of oxygen on required CPGs at CFR Advanced level.

Proposed: John O’ Donnell
Carried without dissent

Seconded: Lawrence Kenna

3. ILCOR Guidelines

In the meeting papers each treatment recommendation of the 2010 ILCOR guidelines, under the headings of Acute Coronary Syndrome, Paediatric Basic and Advanced Life Support, Neonatal Resuscitation and AHA & American Red Cross First Aid, was detailed on a table with comparisons of the AHA and ERC guidelines, along with PHECC’s recommendations for change, where applicable.

Brian Power explained that he sought approval of the broad principles of the recommendations and that the specific details would be dealt with at a later meeting when the relevant CPGs are redrafted for review.

At Sean Walsh’s request it was agreed to discuss Paediatric Basic and Advanced Life Support and Neonatal Resuscitation first.

The following recommendations were agreed:

Part 10: Paediatric Basic and Advanced Life Support

PALS 1 Medical Emergency or Rapid Response Team	Practitioners No change Responders No change
PALS 2 Family Presence During Resuscitation	Practitioners Service providers should make policy decisions in relation to this matter Responders No change
PALS 3 Pulse Check Versus Check for Signs of Life	Practitioners De emphasise pulse checks for cardiac arrest recognition. Responders No change
PALS 4 Focused Echocardiogram to Detect Reversible Causes of Cardiac Arrest	Practitioners No change Responders No change

PALS 5 End-tidal CO₂ (PETCO₂) and Quality of CPR	Practitioners Introduce waveform capnography for Advanced Paramedic level Responders No change
PALS 6 Supplementary Oxygen	Practitioners Following ROSC titrate O ₂ at SPO ₂ 96% to 98% for Paramedics and Advanced Paramedics Responders No change
PALS 7 Cuffed Versus Uncuffed Tracheal Tube	Practitioners No change Responders No change
PALS 8 Tracheal Tube Size	Practitioners No change Responders No change
PALS 9 Bag-Mask Ventilation Versus Intubation	Practitioners No change Responders No change
PALS 10 Bag-Mask Ventilation Versus Supraglottic Airway	Practitioners No change Responders No change
PALS 11 Minute Ventilation	Practitioners No change Responders No change
PALS 12 Devices to Verify Advanced Airway Placement	Practitioners No change Responders No change
PALS 13 Cricoid Pressure	Practitioners No change Responders No change
PALS 14 Compression-Only CPR	Practitioners No change Responders No change
PALS 15 One- Versus 2-Hand Chest Compression in Children	Practitioners No change Responders No change
PALS 16 Circumferential Chest Squeeze in Infants	Practitioners No change Responders No change
PALS 17 Chest Compression Depth	Practitioners Reinforce new compression depths Responders Reinforce new compression depths
PALS 18 Optimal Compression-Ventilation Ratio for Infants and Children	Practitioners No change Responders No change
PALS 19 Newborns (Out of the Delivery Area) Without an Endotracheal Airway	Practitioners No change Responders No change
PALS 20 Newborns (Out of Delivery Area) With a Tracheal Tube	Practitioners No change Responders No change

PALS 21 Intraosseous Access	Practitioners No change Responders No change
PALS 22 Tracheal Drug Delivery	Practitioners No change Responders No change
PALS 23 Paddle Size and Orientation	Practitioners No change Responders No change
PALS 24 Self-Adhesive Pads Versus Paddles	Practitioners No change Responders No change
PALS 25 Number of Shocks	Practitioners No change Responders No change
PALS 26 Energy Dose	Practitioners Defibrillation energy using manual defibrillators to commence with 4 J/Kg for Advanced Paramedics. Responders No change
PALS 27 Amiodarone Versus Lidocaine for Refractory VF/Pulseless VT	Practitioners No change Responders No change
PALS 28 AED Use in Infants	Practitioners Introduce infant defibrillation for Paramedics and Advanced Paramedics. Responders No change
PALS 29 Unstable VT	Practitioners No change Responders No change
PALS 30 Drugs for Supraventricular Tachycardia	Practitioners No change Responders No change
PALS 31 Graded Volume Resuscitation for Hemorrhagic Shock	Practitioners Change to 10 mL/Kg for APs for hemorrhagic (Trauma) Shock – update CPG accordingly Responders No change
PALS 32 Early Ventilation in Shock	Practitioners No change Responders No change
PALS 33 Colloid Versus Crystalloid Fluid Administration	Practitioners Introduce 20 mL/Kg fluid challenge for paediatric Asystole/PEA arrest for Advanced Paramedics. Responders No change
PALS 34 Vasoactive Agents in Distributive Shock	Practitioners No change Responders No change
PALS 35 Vasoactive Agents in Cardiogenic Shock	Practitioners No change Responders No change
PALS 36 Etomidate for Intubation in Hypotensive Septic Shock	Practitioners No change Responders No change

PALS 37 Corticosteroids in Hypotensive Shock	Practitioners No change Responders No change
PALS 38 Diagnostic Tests as Guide to Management of Shock	Practitioners No change Responders No change
PALS 39 Calculating Drug Dose	Practitioners No change Responders No change
PALS 40 Epinephrine Dose	Practitioners No change Responders No change
PALS 41 Sodium Bicarbonate During Cardiac Arrest	Practitioners No change Responders No change
PALS 42 Vasopressin	Practitioners No change Responders No change
PALS 43 Calcium in Cardiac Arrest	Practitioners No change Responders No change
PALS 44 Atropine Versus Epinephrine for Bradycardia	Practitioners No change Responders No change
PALS 45 Extracorporeal Cardiac Life Support	Practitioners No change Responders No change
PALS 46 Hypothermia	Practitioners A CPG for post arrest care for paediatrics be developed for Practitioners Responders A CPG for post arrest care for paediatrics be developed for Responders
PALS 47 Vasoactive Drugs	Practitioners No change Responders No change
PALS 48 Glucose	Practitioners A CPG for post arrest care for paediatrics be developed for Practitioners Responders A CPG for post arrest care for paediatrics be developed for Responders
PALS 49 Channelopathy	Practitioners No change Responders No change
PALS 50 Life Support for Trauma	Practitioners Introduce 20 mL/Kg fluid challenge for paediatric Asystole/PEA arrest for Advanced Paramedics. Responders No change
PALS 51 Single-Ventricle Post Stage I Repair	Practitioners No change Responders No change

PALS 52 Single-Ventricle Post-Fontan and Bidirectional Glenn Procedures	Practitioners No change Responders No change
PALS 53 Pulmonary Hypertension	Practitioners No change Responders No change
PALS 54 Prognosis and Decision to Terminate CPR	Practitioners No change Responders No change
PALS 55 Initial treatment algorithm for paediatric cardiac arrest	Practitioners Maintain ABC initial sequence commencing with 5 rescue breaths Responders Change initial sequence to CAB

Resolution: That the MAG approve PHECC recommendations relating to Part 10 – Paediatric Basic and Advanced Life Support

Proposed: Sean Walsh
Carried without dissent

Seconded: Declan Lonergan

Part 11 – Neonatal Resuscitation

Reference	Recommendations
NR 1 Assessment of Cardiorespiratory Transition and Need for Resuscitation	Practitioners Increase the awareness of the benefit of pulse oximetry for neonatal resuscitation at Paramedic and Advanced Paramedic levels Responders No change
NR2 Use of Supplementary Oxygen	Practitioners No change Responders No change
NR 3 Peripartum Suctioning	Practitioners No change Responders No change
NR 4 Tracheal Suctioning	Practitioners No change Responders No change

<p>NR 5 Ventilation Strategies</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 6 Continuous Positive Airway Pressure</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 7 Assisted Ventilation Devices</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 8 Laryngeal Mask Airway</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 9 Upper Airway Interface Devices</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 10 Exhaled Air Ventilation</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 11 Measurement of Tidal Volume</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 12 Use of Exhaled CO2 Detectors to Confirm Tracheal Tube Placement</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 13 Colorimetric CO2 Detection to Assess Ventilation in Non intubated Patients</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>NR 14 Chest Compressions</p>	<p>Practitioners Two thumb encircling hands technique be adopted for neonate resuscitation for Practitioners</p> <p>Responders No change</p>

NR 15 Route and Dose of Epinephrine	Practitioners No change Responders No change
NR 16 Volume Expansion	Practitioners No change Responders No change
NR 17 Naloxone	Practitioners No change Responders No change
NR 18 Vascular Access	Practitioners No change Responders No change
NR 19 Maintenance of Body Temperature	Practitioners Completely cover newborn babies of < 28 weeks gestation in a polythene wrap or bag up to their necks without drying first for Paramedics and Advanced Paramedics – update CPG appropriately Responders No change
NR 20 Hyperthermia	Practitioners No change Responders No change
NR 21 Therapeutic Hypothermia	Practitioners No change Responders No change
NR 22 Glucose	Practitioners No change Responders No change
NR 23 Timing of Cord Clamping	Practitioners Change practice to emphasise waiting at least one minute post delivery prior to clamping & cutting the umbilical cord for Paramedics and Advanced Paramedics – update CPG appropriately Responders No change
NR 24 Noninitiation of Resuscitation	Practitioners No change Responders No change

NR 25 Discontinuation of Resuscitation	Practitioners No change Responders No change
NR 26 Personnel Needs at Elective Cesarean Sections	Practitioners No change Responders No change
NR 27 Simulation	Practitioners No change Responders No change
NR 28 Briefings and Debriefings	Practitioners No change Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 11 – Neonatal Resuscitation

Proposed: Macartan Hughes
Carried without dissent

Seconded: Cathal O’ Donnell

Part 9: Acute Coronary Syndrome

ACS 1 Demographic Factors	Practitioners No change Responders No change
ACS 2 Accuracy of History and Physical Examination for Diagnosing ACS	Practitioners No change Responders No change
ACS 3 ACS and Nitroglycerin	Practitioners No change Responders No change
ACS 4 12-Lead ECG	Practitioners No change Responders No change
ACS 5 Diagnosis of STEMI by Non physicians	Practitioners Reinforce 12 lead ECG interpretation of STEMI during Paramedic training and include it in continuous professional competence for Ps and APs Responders No change

ACS 6 Computer-Assisted ECG Interpretation	Practitioners Investigate specificity and sensitivity of computer interpretation software for 12 lead ECG and make a recommendation on its use for future purchases of 12 ECG machines Responders No change
ACS 7 Protein Markers of Coronary Ischemia	Practitioners No change Responders No change
ACS 8 Prognosis for Discharge Versus Admission	Practitioners No change Responders No change
ACS 9 Chest Pain Observation Units	Practitioners No change Responders No change
ACS 10 Imaging Techniques and Diagnosis	Practitioners No change Responders No change
ACS 11 Imaging Techniques and Outcome	Practitioners No change Responders No change
ACS 12 Supplemental Oxygen	Practitioners Change O ₂ therapy for ACS to ERC guidelines for EMTs, Ps and APs(94-98%) except for COPD patients, maintain at lower end of range of non COPD patients Responders No change
ACS 13 ACS and Nitroglycerin	Practitioners No change Responders EFRs to monitor BP prior to assisting patient with own GTN
ACS 14 Analgesics and Sedation	Practitioners No change Responders No change
ACS 15 Timing of Aspirin Administration	Practitioners No change Responders No change
ACS 16 Clopidogrel (and Similar Drugs)	Practitioners Refer to ACS group for advice Responders No change
ACS 17 Anticoagulants and Non–ST-Elevation ACS	Practitioners No change Responders No change
ACS 18 Anticoagulants and STEMI Treated With Fibrinolysis	Practitioners No change Responders No change
ACS 19 Anticoagulants and STEMI Treated With PCI	Practitioners No change Responders No change
ACS 20 Glycoprotein IIb/IIIa Inhibitors	Practitioners No change Responders No change

ACS 21 Prehospital Fibrinolytics for STEMI	Practitioners Review and update Indications and Contraindications for PHT for APs– refer to ACS group for advice Responders No change
ACS 22 PPCI Versus Fibrinolytic Therapy for STEMI	Practitioners No change Responders No change
ACS 23 Fibrinolytics and Immediate PCI (Facilitated PCI) Versus Immediate PCI	Practitioners No change Responders No change
ACS 24 Prophylactic Antiarrhythmics	Practitioners No change Responders No change
ACS 25 β-Blockers	Practitioners No change Responders No change
ACS 26 Angiotensin Converting Enzyme (ACE) Inhibitors and Angiotensin Receptor Blockers (ARBs)	Practitioners No change Responders No change
ACS 27 A & B Statins	Practitioners No change Responders No change
ACS 28 Prehospital ECGs	Practitioners No change Responders No change
ACS 29 Improving Systems of Care for ACS	Practitioners Mandatory reporting of suspected ACS patient to ambulance control. Develop protocols to ensure appropriate integrated hospital and EMS response to ACS - ACS group to advise Responders No change
ACS 30 Out-of-Hospital Triage for PCI	Practitioners Mandatory reporting of suspected ACS patient to ambulance control. Develop protocols to ensure appropriate integrated hospital and EMS response to ACS - ACS group to advise Responders No change
ACS 31 PCI Following ROSC	Practitioners ROSC pathway to appropriate facility according to local protocol- ACS group to advise Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 9 – Acute Coronary Syndrome.

Proposed: John O’ Donnell
Carried without dissent

Seconded: Macartan Hughes

Part 13: AHA & American Red Cross First Aid Guidelines

FA 1 Treatment Recommendation (caustic substance)	Practitioners Not applicable Responders Develop CPG for poisons
FA 2 Treatment Recommendations (ipecac syrup) & (active charcoal)	Practitioners Not applicable Responders Develop CPG for poisons
FA 3 Treatment Recommendation (anaphylaxis)	Practitioners Not applicable Responders Develop CPG for anaphylaxis
FA 4 Treatment Recommendation (anaphylaxis & epinephrine)	Practitioners Not applicable Responders Develop CPG for anaphylaxis
FA 5 Treatment Recommendations (oxygen therapy)	Practitioners Not applicable Responders No change
FA 6 Treatment Recommendation (aspirin for ALS)	Practitioners Not applicable Responders No change
FA 7 Treatment Recommendations (recovery position)	Practitioners Not applicable Responders No change
FA 8 Treatment Recommendation (shock)	Practitioners Not applicable Responders Develop a CPG for shock
FA 9 When to suspect a cervical spine trauma	Practitioners Not applicable Responders Outline list of spinal injury risk factors on CPGs
FA 10 Benefits of spinal immobilization	Practitioners Not applicable Responders No change
FA 11 Method of spinal motion restriction	Practitioners Not applicable Responders No change
FA 12 Thermal Cutaneous Burns	Practitioners Not applicable Responders Add maximum time for cooling onto CPG
FA 13 Blisters	Practitioners Not applicable Responders Add caution re bursting blisters onto CPG
FA 14 Direct Pressure, Pressure Points, and Elevation	Practitioners Not applicable Responders Develop CPGs for haemorrhage control
FA 15 Tourniquets – Routine Use	Practitioners Not applicable Responders Develop CPGs for haemorrhage control
FA 16 Tourniquets – When Should They be Used?	Practitioners Not applicable Responders Develop CPGs for haemorrhage control

FA 17 Haemostatic agents	Practitioners Not applicable Responders Develop CPGs for haemorrhage control
FA 18 Straightening an angulated fracture	Practitioners Not applicable Responders No change
FA 19 Stabilizing Suspected Extremity Fracture	Practitioners Not applicable Responders No change
FA 20 Musculoskeletal Injury and Heat Application	Practitioners Not applicable Responders Develop a CPG for soft tissue injuries
FA 21 Musculoskeletal Injury and Cold Application	Practitioners Not applicable Responders Develop a CPG for soft tissue injuries
FA 22 Topical Agents and Dressings	Practitioners Not applicable Responders Develop a CPG for soft tissue injuries
FA 23 Irrigation of Superficial Wounds	Practitioners Not applicable Responders Develop a CPG for soft tissue injuries
FA 24 Eye Injury – Irrigation	Practitioners Not applicable Responders No change
FA 25 Treatment Recommendation (bites)	Practitioners Not applicable Responders No change
FA 26 Treatment Recommendation (snake bites)	Practitioners Not applicable Responders No change
FA 27 Treatment Recommendation (snake bites)	Practitioners Not applicable Responders No change
FA 28 Treatment Recommendation (jelly fish sting)	Practitioners Not applicable Responders No change
FA 29 Treatment Recommendation (jelly fish sting)	Practitioners Not applicable Responders No change
FA 30 Treatment Recommendation (jelly fish sting)	Practitioners Not applicable Responders Add jelly fish sting to new CPG for poisons
FA 31 Treatment Recommendation (frost bite)	Practitioners Not applicable Responders Develop a CPG for environmental injuries
FA 32 Treatment Recommendations (frost bite)	Practitioners Not applicable Responders Develop a CPG for environmental injuries

FA 33 Treatment Recommendations (hypohydration)	Practitioners Not applicable Responders Develop a CPG for environmental injuries
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Resolution: That the MAG approve PHECC recommendations relating to Part 13 – First Aid

Proposed: Niamh Collins
Carried without dissent

Seconded: Cathal O’ Donnell

4. ILCOR updated CPGs

- BLS
- ALS
- Miscellaneous

Brian Power informed the group that any CPG identified with asterisks need to be discussed as priority as the decisions relating to these CPGs will impact on the production of the CFR training DVD and manual which is currently being developed.

All CPGs included in the papers went through a Delphi process, the results of which were also in the papers. Brian Power detailed further Delphi responses which were submitted to the office after the meeting papers were disseminated. It was agreed to discuss primarily the comments of members who disagreed with the proposed changes to the draft CPGs.

1/2/3.4.1-2 Basic Life Support- Adult (V2.2)

The following was agreed:

- Re-word ‘Not breathing normally?’ to read ‘Not breathing normally? i.e. gasping’
- change maximum hands off time from 15 seconds in 2 minutes to ‘ while CPR ongoing maximum hands off time 10 seconds’
- Change chest compression depth from ‘5 cm’ to ‘at least 5 cm’
- Include ‘ continue CPR while AED is charging’

Resolution: CPG 1/2/3.4.1-2 Basic Life Support - Adult (V 2.2) be approved subject to the changes agreed above.

Proposed: Mark Doyle
Carried without dissent

Seconded: Valerie Small

1/2/3.4.4-3 Basic Life Support – Paediatric (≤ 13 Years) (V3.2)

The following was agreed:

- Re-word ‘Not breathing normally?’ to read ‘Not breathing normally? i.e. gasping’
- change maximum hands off time from 15 seconds in 2 minutes to ‘ while CPR ongoing maximum hands off time 10 seconds’
- Include ‘ continue CPR while AED is charging’

Resolution: CPG 1/2/3.4.4-3 Basic Life Support - Paediatric (≤ 13 Years) (V3.2) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Macartan Hughes

4.3.1 Advanced Airway Management – Adult (V0.1)

The following was agreed:

- Include entry point from BLS – Adult
- Include ‘while CPR ongoing maximum hands off time to 10 seconds’
- Re-word ‘check tube placement’ to ‘check supraglottic placement’
- Remove CO₂ detection device

Resolution: CPG 4.3.1 Advanced Airway Management - Adult (V0.1) be approved subject to the changes agreed above.

Proposed: John O’ Donnell
Carried without dissent

Seconded: Lawrence Kenna

1/2/3.4.14-2 Post-Resuscitation Care – Adult (V2.3)

The following was agreed:

- Remove ‘consider active cooling if unresponsive’
- Remove equipment list
- Re-word ‘recovery position’ to read ‘ recovery position if no trauma’

Resolution: CPG 1/2/3.4.14-2 Post-Resuscitation Care – Adult (V2.3) be approved subject to the changes agreed above.

Proposed: John O’ Donnell
Carried without dissent

Seconded: Niamh Collins

1/2/3.7.17 Post-Resuscitation Care – Paediatric (V0.2)

The following was agreed:

- Combine the Post Resuscitation Care – Adult & Post Resuscitation Care – Paediatric CPGs into one CPG

Resolution: CPG 1/2/3.7.17 Post-Resuscitation Care – Paediatric (V0.2) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Macartan Hughes

4/5/6.2.1 Primary Survey Medical – Adult (V1.1)

The following was agreed:

- Re- word 'airway patent' to read 'airway patent and protected'
- Re-word 'breathing' to read 'breathing adequate'
- Direct to clinical decision if 'breathing is inadequate' thereafter to appropriate CPG

Resolution: CPG 4/5/6.2.1 Primary Survey Medical - Adult (V1.1) be approved subject to the changes agreed above.

Proposed: Lawrence Kenna
Carried without dissent

Seconded: Stephen Cusack

4/5/6.2.2 Primary Survey Trauma – Adult (V1.1)

The following was agreed:

- Re- word 'airway patent' to read 'airway patent and protected'
- Re-word 'breathing' to read 'breathing adequate'
- Direct to clinical decision if 'breathing is inadequate' thereafter to appropriate CPG
- Re- word 'arrest major external haemorrhage' to read 'arrest major life threatening external haemorrhage' and move to top of CPG under 'scene safety'

Resolution: CPG 4/5/6.2.2 Primary Survey Trauma – Adult (V1.1) be approved subject to the changes agreed above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Macartan Hughes

4/5/6.4.1 Basic Life Support – Adult (V1.2)

The following was agreed:

- Change chest compression depth from '5 cm' to 'at least 5 cm'
- Include 'continue CPR while AED is charging'
- Add '(1 in 6 sec)' in ventilation box
- Consider 'change to manual mode for P & AP'

Resolution: CPG 4/5/6.4.1 Basic Life Support - Adult (V1.2) be approved subject to the changes agreed above.

Proposed: Mark Doyle
Carried without dissent

Seconded: Declan Lonergan

4/5/6.7.1 Primary Survey Medical – Paediatric (≤ 13 Years) (V1.1)

The following was agreed:

- Take out arrow to the right – ‘sick child – no’
- Re- word ‘Pulse < 60’ to read ‘Pulse < 60 and signs of poor perfusion’

Resolution: CPG 4/5/6.7.1 Primary Survey Medical – Paediatric (≤ 13 Years) (V1.1) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: John O’ Donnell

4/5/6.7.2 Primary Survey Trauma – Paediatric (≤ 13 Years) (V1.1)

The following was agreed:

- Take out arrow to the right – ‘sick child – no’
- Re- word ‘Pulse < 60’ to read ‘Pulse < 60 and signs of poor perfusion’
- Re- word ‘arrest major external haemorrhage’ to read ‘arrest major life threatening external haemorrhage’ and move to top of CPG under ‘scene safety’

Resolution: CPG 4/5/6.7.2 Primary Survey Trauma – Paediatric (≤ 13 Years) (V1.1) be approved subject to the changes agreed above.

Proposed: Mark Doyle
Carried without dissent

Seconded: Lawrence Kenna

3.7.3 Primary Survey - Paediatric (≤ 13 Years) (V1.1)

The following was agreed:

- Re- word ‘arrest major external haemorrhage’ to read ‘arrest major life threatening external haemorrhage’ and move to top of CPG under ‘scene safety’

Resolution: CPG 3.7.3 Primary Survey – Paediatric (≤ 13 Years) (V1.1) be approved subject to the changes agreed above.

Proposed: Stephen Cusack
Carried without dissent

Seconded: Niamh Collins

4/5/6.4.2 Basic Life Support – Paediatric (≤ 13 Years) (V1.1)

The following was agreed:

- Re-word ‘Cardiac arrest or pulse < 60 per minute’ to read ‘Cardiac arrest or pulse < 60 per minute and signs of poor perfusion’
- Only AP’s authorized to ‘Change defibrillator to manual mode (4 J/kg)’

- Include 'continue CPR while AED is charging'
- 1st and subsequent shocks – 4 joules / Kg

Resolution: CPG 4/5/6.4.2 Basic Life Support – Paediatric (≤ 13 Years) (V1.1) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Niamh Collins

4/5/6.4.7 VF or Pulseless VT – Adult (V1.2)

The following was agreed:

- Re-word 'Sodium Bicarbonate 50 mL IV' to read "Sodium Bicarbonate 8.4% 50 mL IV"
- Insert 'hang 500 mL saline as flush'
- Increase the size of 'CPR x 2 minutes' box to incorporate the maximum space in the circle
- Move 'Defibrillate', 'Rhythm check *' and VF/VT boxes closer together
- Insert 'Consider transport to ED if no change after 20 minutes resuscitation'
- Insert 'Mechanical CPR device is the optimum care during transport'
- Insert 'drive smoothly' warning

Resolution: CPG 4/5/6.4.7 VF or Pulseless VT – Adult (V1.2) be approved subject to the changes agreed above.

Proposed: John O' Donnell
Carried without dissent

Seconded: Lawrence Kenna

4/5/6.4.11 Pulseless Electrical Activity – Adult (V1.1)

The following was agreed:

- Re-word 'Sodium Bicarbonate 50 mL IV' to read "Sodium Bicarbonate 8.4% 50 mL IV"
- Insert 'hang 500 mL saline as flush'
- Increase the size of 'CPR x 2 minutes' box to incorporate the maximum space in the circle
- Move 'Rhythm check *' and 'PEA' boxes closer together
- Insert 'Consider transport to ED if no change after 20 minutes resuscitation'
- Insert 'Mechanical CPR device is the optimum care during transport'
- Insert 'drive smoothly' warning
- Under 'Consider fluid challenge' change Hartmann's solution to NaCl

Resolution: CPG 4/5/6.4.11 Pulseless Electrical Activity –Adult (V1.1) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Lawrence Kenna

5/6.4.10 Asystole – Adult (V1.2)

The following was agreed:

- Re-word 'Sodium Bicarbonate 50 mL IV' to read "Sodium Bicarbonate 8.4% 50 mL IV"
- Insert 'hang 500 mL saline as flush'
- Increase the size of 'CPR x 2 minutes' box to incorporate the maximum space in the circle
- Move 'Rhythm check *' and 'Asystole' boxes closer together
- Under 'Consider fluid challenge' change Hartmann's solution to NaCl

Resolution: CPG 5/6.4.10 Asystole – Adult (V1.2) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Cathal O' Donnell

4.4.10 Asystole – Adult (V1.1)

The following was agreed:

- Increase the size of 'CPR x 2 minutes' box to incorporate the maximum space in the circle
- Move 'Rhythm check *' and 'Asystole' boxes closer together
- Insert 'Consider transport to ED if no change after 20 minutes resuscitation'
- Insert 'Mechanical CPR device is the optimum care during transport'
- Insert 'drive smoothly' warning

Resolution: CPG 1.4.10 Asystole – Adult (V1.1) be approved subject to the changes agreed above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Cathal O' Donnell

Due to time constraints the remainder of the agenda was postponed until the next meeting.

7. A.O.B.

It was agreed that MAG meetings will now commence at 10.00am instead of 10.30am.

The next MAG meeting will be held in the PHECC office Naas, on Thursday 24th March 2011, from 10.00am until 3.00pm.

The Chair thanked the group for their attendance.

Signed: _____

Date: _____

The Medical Advisory Group
Minutes 2nd June 2011, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Niamh Collins
Sean Walsh
Lawrence Kenna
Declan Lonergan
Macartan Hughes
Frank O' Malley
Cathal O' Donnell
Sean O' Rourke
Conor Egleston
Brendan Whelan
Stephen Cusack
Valerie Small
Gerry Bury

Present

Geoff King (Director)
Brian Power
Marion O' Malley

Apologies

John O'Donnell
David Menzies
David Janes
Mark Doyle

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. The Chair congratulated Cathal O' Donnell and the Resus Conference Committee on the success of the recent conference in Limerick.

2. Minutes and Matters Arising

Niamh Collins suggested that the wording of the manual defibrillation policy was too proscriptive and could result in medico legal issues in the future. This issue was debated and details of the deliberations are outlined below.

Resolution: That the minutes from the Medical Advisory Group meeting of 24th March 2011 be approved.

Proposed: Macartan Hughes
Carried without dissent

Seconded: Declan Lonergan

3. CPG updates

ACS for Ps & APs

Included in the papers was correspondence from PHECC to the ACS Programme along with a response paper from Susan Hennessy on behalf of the ACS Programme. The ACS CPG as presented, although following the direction from the ACS Programme, was complex in relating to decision making for the Practitioner. The special instructions for pre-hospital thrombolysis modified to suit this updated CPG were felt to be appropriate. Gerry Bury suggested that in order to make the CPG compatible for medical practitioners that the age restriction of < 75 years for thrombolysis is made discretionary for medical practitioners. It was felt that the decision for PPCI should be made simpler and not multifaceted with several age and time frames in the equation. Following discussion on the evidence base for protocol decisions it was agreed that the group revert back to Prof Kieran Daly and the ACS Programme for further guidance and clarification regarding:

- Definition of Large STEMI
- Age limit 65 v 75
- 60 minutes v 90 minutes to PPCI

Following further consultation this CPG will be brought back to MAG for consideration.

Stephen Cusack commended Susan Hennessy, the author of the ACS evidence based paper, on a very well written document.

Cathal O' Donnell suggested that the format and layout of all CPGs be looked at in order to standardise them. It was agreed that this be considered at a future date when 4th Edition CPGs are in development.

Recognition of Death – Resuscitation not Indicated (5/6.4.15);

Brian Power sought approval of this updated CPG. The original CPG included a DNR component, which was removed and is now incorporated in the End of Life – DNR CPG. No other changes were made to this CPG.

The Director informed the group that the End of Life Forum is currently exploring the prospect whereby paramedics and nurses could pronounce a death, a practice which currently takes place in the UK.

Resolution: That CPG– Recognition of Death – Resuscitation not Indicated (5/6.4.15) be approved.

Proposed: Stephen Cusack
Carried without dissent

Seconded: Valerie Small

Infant Defibrillation

Brian Power informed the group that following a policy decision made by MAG differences have emerged between AHA (IHF) and PHECC teaching on infant defibrillation. AHA teaching advised students to attempt infant defibrillation if presented with an infant in cardiac arrest whereas PHECC has

confined infant defibrillation to APs & Ps (MAG, 24th March 2011). Brian Power suggested that there were two options available to the group:

- 1 Continue the restriction for infant defibrillation to APs and Ps
- 2 Authorise infant defibrillation on PHECC CPGs for all clinical levels and insert a text box on the appropriate CPGs with an explanation about infant defibrillation.

It was agreed that on CPGs VF or Pulseless VT – Paediatric (4/5/6.4.8) and Basic Life Support – Paediatric (1/2/3.4.4) to take off restrictions regarding EMTs and Responders not being authorised to defibrillate, and to insert a text box on the appropriate CPGs with an explanation about infant defibrillation. The following text was agreed:

‘It is extremely unlikely to ever have to defibrillate a child less than 1 year old. Nevertheless, if this were to occur the approach would be the same as for a child over the age of 1. The only likely difference being, the need to place the defibrillation pads anterior (front) and posterior (back), because of the infant’s small size’.

Resolution: That restrictions be lifted on CPGs VF or Pulseless VT – Paediatric (4/5/6.4.8) and Basic Life Support – Paediatric (1/2/3.4.4) regarding EMTs and Responders not being authorised to defibrillate infants, and to insert text, as above, on the appropriate CPGs with an explanation about infant defibrillation.

Proposed: Sean Walsh
Carried without dissent

Seconded: Gerry Bury

Defibrillation method and energy for paediatric patients

A discussion took place on the defibrillation method and energy for paediatric patients. Sean Walsh outlined his preference for accurate energy levels being used for paediatric defibrillation thus favouring manual defibrillation when the appropriate skill level was available.

This reopened the debate on the policy decision in relation to pre-hospital manual defibrillation. Taking the concerns raised by Niamh Collins and the advice from Sean Walsh the pre-hospital defibrillation policy was changed to;

- APs should use manual defibrillation for all age groups
- Ps may (consider) use of manual defibrillation for all age groups
- EMTs and Responders shall use AED mode for all age groups

Resolution: That the pre-hospital defibrillation policy as outlined above is adopted and that all relevant CPGs are updated to reflect this policy and the infant defibrillation policy.

Proposed: Gerry Bury
Carried without dissent

Seconded: Lawrence Kenna

Implantable Cardioverter Defibrillator (ICD) draft wording for consideration in response to representations by an advocacy group

An advocacy group contacted PHECC and expressed concerned about the apparent lack of awareness of ICDs in patients and the consequences for managing an arrest with an ICD or misfiring of an ICD. Draft wording was included in the CPG Basic Life Support – Adult (4/5/6.4.1) for consideration and Brian Power sought ratification prior to approval by Council.

In light of the pre-hospital manual defibrillation policy it was agreed to change ‘Attach AED defibrillation pads’ to read ‘Attach defibrillation pads’ on all appropriate CPGs

Resolution: That CPG Basic Life Support – Adult (4/5/6.4.1) be approved subject to the changes agreed above and that all relevant CPG be changed accordingly.

Proposed: Gerry Bury
Carried without dissent

Seconded: Macartan Hughes

Limb Fracture

The CPG for Limb Fractures – Adult (5/6.6.5) was included in the papers, for review, at the request of Cathal O’ Donnell. It was confirmed that Ps and APs are not currently taught how to re-align a limb and both Cathal O’ Donnell and Gerry Bury proposed that the CPG be amended to reflect current practice.

The following was agreed:

- Re-word ‘Dress open fractures’ to read ‘Dress open wounds and fractures’
- Delete the text boxes ‘CSMs intact; yes/no’, ‘reposition limb (two attempts)’ and ‘recheck CSMs’

Resolution: That CPG Limb Fractures – Adult (5/6.6.5) be approved subject to the changes agreed above.

Proposed: Cathal O’ Donnell
Carried without dissent

Seconded: Valerie Small

4. Medication Formulary

Formulary Updates

Proposed amendments to the Medication Formulary were included in the papers for ratification prior to approval by Council.

The following was agreed:

Amiodarone

- Under ‘Presentation’ amend text to read ‘150 mg in 3 mL solution’
- Under ‘Additional Information’ add text to read ‘If diluted mix with Dextrose 5%. May be flushed with NaCl’.

Hartmann's Solution

- Under 'Indications' insert 'When NaCl is unavailable it may be substituted with Hartmann's Solution IV/IO, except for crush injuries, burns, renal failure and hyperglycaemia'.

Diazepam Injection

- Under 'Class' insert 'Benzodiazepine'
- Under 'Descriptions' insert 'It is a benzodiazepine that is used to terminate seizures'
- Under 'Indications' delete 'sustained seizure activity' and insert 'seizure'
- Under 'Additional Information' add 'The maximum dose of Diazepam includes that administered by caregiver prior to arrival of Practitioner'

Diazepam Rectal Solution

- Under 'Class' insert 'Benzodiazepine'
- Under 'Descriptions' insert 'It is a benzodiazepine that is used to terminate seizures'
- Under 'Indications' delete 'sustained seizure activity' and insert 'seizure'
- Under 'Additional Information' add 'The maximum dose of Diazepam includes that administered by caregiver prior to arrival of Practitioner'

Magnesium Sulphate injection

- Under 'Class' insert 'Electrolyte and Tocolytic agent'
- Under 'Usual Doses' text should read 'Adults: Torsades de pointes: 2 g IV/IO infusion over 15 minutes'
- Under 'Additional Information' insert 'Dilute in 50 mL NaCl for infusion'

Midazolam Solution

- Under 'Dosages' add 'Paediatric: or 0.1 mg/Kg IV/IO'
- Under 'Additional Information' add 'The maximum dose of Midazolam includes that administered by caregiver prior to arrival of Practitioner'

Nifedipine

- Under 'Class' delete 'Tocolytic agent' and insert 'Calcium channel blocker'
- Amend 'Class' to 'dihydropyridine'

Salbutamol

- Under 'Additional Information' add 'If an oxygen driven nebulizer is used to administer Salbutamol for a patient with acute exacerbation of COPD it should be limited to 6 minutes maximum'

Resolution: That the proposed amendments to the Medication Formulary be approved subject to the changes listed above.

Proposed: Valerie Small
Carried without dissent

Seconded: Stephen Cusack

Following a brief discussion regarding the decision making process of the Medical Advisory Group a policy decision was made whereby all updated CPGs are signed off by the MAG at the July 2011 meeting.

Resolution: That all updated CPGs be and signed off by MAG at the July 2011 meeting.

Proposed: Cathal O' Donnell
Carried without dissent

Seconded: Macartan Hughes

Medication Queries

Two queries were detailed in the papers for deliberation.

1. Morphine Sulphate

Dr Ciara Martin was concerned that meningitis was not listed on the formulary as a contraindication for its use.

The consensus of the group was that it is not a contraindication.

2. Magnesium Sulphate

Could the indications for MgSO₄ include eclamptic seizures for pregnant women?

While the group agreed that Magnesium Sulphate reliably prevents seizures the overall consensus was that PHECC should consult with the Obstetrics Programme prior to making a recommendation.

5. EMS Priority Dispatch Sub Group Terms of Reference

The EMS Priority Dispatch Sub Group currently is an ad-hoc group brought together to review and advise MAG on the clinical detail within AMPDS which has been recommended for EMS in Ireland. As priority dispatch issues continue to emerge and it is anticipated that there is an ongoing need for such a group the proposal is to formalise this important sub group. In order to formalise the EMS Priority Dispatch Sub Group the draft Terms of Reference were included in the papers for recommendation. This was welcomed by the group and suggestions were made to re-convene the group as soon as possible.

Resolution: That the EMS Priority Dispatch Sub Group Terms of Reference be recommended to Council for approval.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Macartan Hughes

6. AVPU Definition

A concern arose in a recent NQEMT exam where two examiners disagreed about the definition of 'Alert' on the AVPU scale. Brian Power asked that the MAG define AVPU from a pre-hospital perspective to avoid confusion on findings and reporting of patient assessment. It was agreed that 'Alert' be defined as 'awake and interacting with the environment'. Reference to orientation should be reported separately.

The definition of AVPU for a pre-hospital emergency care perspective is therefore:-

A = Alert; awake and interacting with the environment
V = response to voice; not alert (as defined above) but responding to verbal stimuli
P = response to pain; does not respond to voice but responds only to painful stimuli
U = unresponsive; does not respond to any stimuli

Resolution: That the AVPU definitions as outlined above be adopted for pre-hospital emergency care use.

Proposed: Stephen Cusack
Carried without dissent

Seconded: Declan Lonergan

7. Medicinal Products Schedule Update

Included in the papers was the updated Medicinal Products Schedule which will be sent to the Department of Health and Children for statutory approval. Approval of the listed medications by the Department authorises PHECC registered Practitioners to administer the listed medications legally according to CPGs. Brian Power informed the group that it normally takes up to one year for the Medicinal Products list to be updated and asked that the group review the list with a view to anticipating future needs. Cathal O' Donnell suggested that the schedule be looked at in more detail and it was agreed that this agenda item be re-visited at the July meeting. Members of MAG should be invited to suggest possible medications for inclusion.

8. AOB

Sean Walsh detailed a recent case in OLCHC and was looking for clarity regarding the multiple dose administration of medication for seizures. The issue of the treat and refer guidelines was referred to, as well as concern over MAG members being legally protected, should a CPG be incorrectly followed. Following some discussion on these items it was agreed that the specific case be discussed outside the meeting by the relevant parties, but that the seizures CPG be discussed at the next MAG meeting.

A paper on Intranasal Naloxone in the treatment of opioid overdose, written by Dr Cian McDermott, was discussed. Niamh Collins gave a brief synopsis of the paper and outlined that the main issue surrounding the use of intranasal Naloxone in Ireland is the concentration. Having contacted two drug companies they were not interested in supplying the Irish market. There was general support for intranasal Naloxone and Cathal O' Donnell confirmed that if it was available here the NAS would be in a position to use it. It was agreed that PHECC write to drug companies outlining its position and report back to the MAG with any correspondence.

Dr Ciarán Browne is conducting research on pre-hospital CPAP and requested that his paper be considered by MAG. Brian Power following discussion with Dr Browne drafted and tabled a CPG, Acute Pulmonary Oedema for discussion and asked that if CPAP was implemented in Ireland, what level of practitioner it should apply to. The consensus was that if introduced it

would be at AP level. Stephen Cusack informed the group that an appropriate test B-type Natriuretic peptide (BNP) could now be carried out to confirm pulmonary oedema. This test may be available as a near patient test. Macartan Hughes asked what the benefit would be if the hospital cannot pursue a treatment given in an ambulance. The general consensus was that the group agreed with the concept but felt it was not an appropriate time to develop the CPG due to the current upskilling workload. This draft CPG will be brought back to the group at a later stage.

Cathal O' Donnell asked about the status of the Pain Management CPG as the NAS are currently re-applying for a Morphine licence and are running into some difficulty obtaining the licence as the CPG is not currently published and an interim directive is in place until December 2011. Brian Power confirmed that the CPG has been approved by Council and agreed to send correspondence to Cathal O' Donnell, detailing its status.

The next meeting will take place on Thursday 7th July 2011 at 10am in the PHECC office. The Chair thanked the group for their attendance. There being no further business the meeting concluded.

Signed: _____

Dr. Zelig Gaffney
Chairperson

Date: _____

The Medical Advisory Group
Minutes 24th March 2011, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Paul Lambert
Peter O' Connor
David Menzies
Niamh Collins
Mark Doyle
Sean Walsh
Lawrence Kenna
Declan Lonergan
Macartan Hughes
Frank O' Malley
Cathal O' Donnell
Sean O' Rourke
Conor Egleston

Present

Geoff King (Director)
Brian Power
Shane Knox
Marion O' Malley

Apologies

John O'Donnell
Brendan Whelan
Stephen Cusack
Valerie Small
David Janes

1. Chair's Business

The Chair opened the meeting by notifying members of the resignation of Fergal Hickey. Apologies were acknowledged. The Chair acknowledged the good work of the Resus Conference Committee and wished Cathal O' Donnell well for the upcoming conference, April 1st & 2nd.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 24th February 2011 be approved.

Proposed: Macartan Hughes
Carried without dissent

Seconded: Declan Lonergan

3. ILCOR updated draft CPGs

Nine CPGs were tabled for approval. These CPGs will impact on the production of the CFR training DVD and manual which is currently being developed and Brian Power informed the group that they were discussed at the February meeting and now require formal sign off.

1/2/3.4.1-2 Basic Life Support- Adult (V2.7)

The following was agreed:

- Include '30:2 ratio' following 'CPR' in the 'Commence Chest Compressions' box

1/2/3.4.4-3 Basic Life Support – Paediatric (≤ 13 Years) (V3.6)

The following was agreed:

- Re-word 'For < 8 years use paediatric defibrillation to 'From 1-8 years use paediatric defibrillation system'
- Include '30:2 ratio' following 'CPR' in the 'Commence Chest Compressions' box

1/2/3.4.5-2 Foreign Body Airway Obstruction – Adult (V2.3)

The following was agreed:

- After 'encourage cough' remove 'breathing normally' and 'Go to BLS Adult CPG'

1/2/3.4.6-2 Foreign Body Airway Obstruction – Paediatric (≤ 13 Years) (V2.3)

The following was agreed:

- After 'encourage cough' remove 'breathing normally' and 'Go to BLS Child CPG'

1/2/3.4.14-2 Post-Resuscitation Care – Adult (V2.5)

The following was agreed:

- No changes identified

1/2/3.4.15-2 Recognition of Death – Resuscitation not Indicated

This CPG was presented for information only as there was no change to this CPG following the ILCOR 2010 recommendations.

1/2/3.4.16.1 Cardiac Chest Pain – Acute Coronary Syndrome (Draft 1.2)

The following was agreed:

- Move 'Call 999/112 if not already contacted' and place immediately after 'Cardiac Chest Pain'

1/2/3.4.22 Stroke (V1.2)

The following was agreed:

- No changes identified

4.3.1 Advanced Airway Management – Adult (V0.5)

The following was agreed:

- No changes identified

A discussion ensued regarding the benefits of capnography and it was agreed that Cathal O’ Donnell explore its value for pre-hospital care.

Resolution: That the following CFR CPGs be approved subject to the changes agreed above.

CPG 1/2/3.4.1-2 Basic Life Support - Adult (V 2.7)

CPG 1/2/3.4.4-3 Basic Life Support – Paediatric (≤ 13 Years) (V3.6)

CPG 1/2/3.4.5-2 Foreign Body Airway Obstruction – Adult (V2.3)

CPG 1/2/3.4.6-2 Foreign Body Airway Obstruction – Paediatric (≤ 13 Years) (V2.3)

CPG 1/2/3.4.14-2 Post-Resuscitation Care – Adult (V2.5)

CPG 1/2/3.4.16.1 Cardiac Chest Pain – Acute Coronary Syndrome (Draft 1.2)

CPG 1/2/3.4.22 Stroke (V1.2)

CPG 4.3.1 Advanced Airway Management - Adult (V0.5)

Proposed: Peter O’ Connor
Carried without dissent

Seconded: Niamh Collins

The CPGs not discussed at the last meeting were represented for approval. They were updated following recommendations at the February 2011 meeting.

4/5/6.4.8 VF or Pulseless VT – Paediatric (≤ 13 Years) (V1.3)

The following was agreed:

- Re-word ‘initial epinephrine between 1st and 4th shock’ to ‘initial epinephrine between 2nd and 4th shock’ (this change to be made on Adult VF/VT CPG also)
- APs to consider waveform capnography
- Re-align ‘red boxes’ on the page
- Confine defibrillation of infants to APs & Ps

A policy decision was made in relation to pre-hospital manual defibrillation:

- APs should use manual defibrillation for all age groups
- Ps may (consider) use of manual defibrillation for adults and shall use AED mode for paediatric patients
- EMTs and responders shall use AED mode for all age groups

Resolution: CPG 4/5/6.4.8 VF or Pulseless VT – Paediatric (≤ 13 Years) (V1.3) be approved subject to the changes agreed above and the policy decision on pre-hospital manual defibrillation be adopted.

Proposed: Declan Lonergan
Carried without dissent

Seconded: David Menzies

4/5/6.4.12 Asystole/PEA – Paediatric (≤ 13 Years) (V1.3)

Resolution: CPG 4/5/6.4.12 Asystole/PEA – Paediatric (≤ 13 Years) (V1.3) be approved.

Proposed: Peter O' Connor
Carried without dissent

Seconded: Sean O' Rourke

5/6.3.1 Advanced Airway Management – Adult (≥ 8 years) (V1.2)

The following was agreed:

- The CPG to be redrafted with a single arm. The decision on the use of endotracheal intubation or supraglottic airway be made by the AP on the scene
- Remove 'position for intubation restricted'
- Delete 'consider impedance threshold device (ITD) if primary cardiac arrest'
- Re-word 'advanced paramedics to use waveform capnography' to 'advanced paramedics consider waveform capnography'

It was agreed that approval be sought, in principle, and that Brian Power would disseminate the updated CPG for immediate review.

Resolution: CPG 5/6.3.1 Advanced Airway Management – Adult (≥ 8 years) (V1.2) be approved in principle subject to the changes agreed above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Mark Doyle

4.4.14 Post Resuscitation Care – Adult (V1.2)

Resolution: CPG 4.4.14 Post Resuscitation Care– Adult (V1.2) be approved.

Proposed: David Menzies
Carried without dissent

Seconded: Sean O' Rourke

5/6.4.4.14 Post Resuscitation Care – Adult (V1.2)

A discussion ensued regarding the benefits of Hartmann's over NaCl as an IV fluid for pre-hospital emergency care. The consensus was that Hartmann's and NaCl are probably interchangeable for all pre-hospital emergency care use except crush injuries and hyperglycaemia where NaCl are preferable. It was stated that best practice is to have only one fluid type available to avoid confusion.

A policy decision was made in relation to pre-hospital IV fluids.

- Replace Hartmann's with NaCl in all CPGs.
- Hartmann's to still be considered a suitable option if NaCl not available.

The following was agreed:

- Change 'Hartmann's solution' to 'NaCl'
- Remove '32° C'
- Delete Sodium Bicarbonate
- Delete Amiodarone infusion
- Change 'if hypotensive consider' to 'if persistent hypotension consider'
- Reduce maintain Sys BP from 100 mmHg to 90 mmHg

Resolution: CPG 5/6.4.4.14 Post Resuscitation Care – Adult (V1.2) be approved subject to the changes agreed above and the policy decision on pre-hospital IV fluids be adopted.

Proposed: Peter O' Connor
Carried without dissent

Seconded: Cathal O' Donnell

4.7.17 Post Resuscitation Care – Paediatric (V0.3)

Resolution: CPG 4.7.17 Post Resuscitation Care – Paediatric (V0.3) be approved.

Proposed: Niamh Collins
Carried without dissent

Seconded: Peter O' Connor

5/6.7.17 Post-Resuscitation Care – Paediatric (V0.3)

The following was agreed:

- Remove targeted temperature of 32°C
- Remove NaCl at 4°C
- Change 'if hypotensive consider' to 'if persistent poor perfusion consider'

- Delete reference to systolic BP maintenance

Resolution: CPG 5.6.7.17 Post-Resuscitation Care – Paediatric (V0.3) be approved.

Proposed: David Menzies
Carried without dissent

Seconded: Sean O' Rourke

4. CPG updates
 - ACS
 - Pain Management

5/6.4.16 Cardiac Chest Pain – Acute Coronary Syndrome (V1.5)

A definition of STEMI be inserted in a text box separate to indications for thrombolysis.

It was agreed to revert to the ACS group before publishing this CPG.

4/5/6.2.6 Pain Management – Adult (V1.2)

The following was agreed:

- Move 'Nitrous Oxide & Oxygen, inh' to 'moderate pain' column
- Include 'Paracetamol and/or Ibuprofen 400 mg PO' in 'moderate pain' column
- Include 'and/or Nitrous Oxide & Oxygen, inh' in 'severe pain' column
- Re-word 'to administer Morphine 10 mg IM' to read 'to administer Morphine up to 10 mg IM' in special authorisation
- Add 'consider other non pharmacological interventions' at base of pain ladder

Resolution: CPG 4/5/6.2.6 Pain Management – Adult (V1.2) be approved subject to the changes agreed above.

Proposed: Mark Doyle
Carried without dissent

Seconded: Peter O' Connor

4/5/6.7.14 Pain Management – Paediatric (≤ 13 Years)(V1.2)

The following was agreed:

- Move 'Nitrous Oxide & Oxygen, inh' to 'moderate pain' column and 'severe pain' column
- Include 'paracetamol and/or ibuprofen in 'moderate pain' column
- Move 'Morphine 0.3 mg/Kg PO to top of 'severe pain' column
- Re-word 'max: 0.15 mg/Kg IV' to Max: 0.1 mg/kg IV'

- Re-word 'Morphine PO > 1 year old only' to read 'Morphine PO > 1 year old only up to max 10 mg'
- Add 'max 4 mg' to ondansetron
- Delete 'cyclizine'
- Add 'consider other non pharmacological interventions' at base of pain ladder

Resolution: CPG 4/5/6.7.14 Pain Management – Paediatric (≤ 13 Years) (V1.2) be approved subject to the changes agreed above.

Proposed: David Menzies
Carried without dissent

Seconded: Niamh Collins

Cathal O' Donnell suggested a re-print of the CPG manuals as there are now a number of updated or new CPGs following the publication of the 2010 ILCOR Guidelines. The Director welcomed suggestions from the group in relation to keeping the information current and ensuring all practitioners have the correct version of the CPGs. He did suggest that updates would be in electronic format and available from the PHECC website at all times. Frank O' Malley commented that a number of practitioners prefer having a manual to refer to.

Sean Walsh asked the Chair if there was any formal audit carried out on any of the CPGs since they were approved. The meeting was informed that Danny O' Regan, T&D HSE South, had developed a spreadsheet to capture AP interventions and CPGs utilised. This spreadsheet has been adopted by the AP Programme in NASC/UCD for undergraduate internship. There is no data for other clinical levels that PHECC is aware of.

5. On line Medical Advice

Brian Power explained that while the development of online medical advice for APs was welcome, currently it is an ad hoc process, and that where you are in the country determines whether you get advice or not. He advised the group that Professor Stephen Cusack has agreed to manage a centre for AP pre-hospital advice in Cork, on behalf of the HSE, where a consultant or senior registrar would be available to take a call at any time. It was suggested that some notification of this service be included in the AP CPG manual and the Practitioner Field Guide. PHECC are to liaise with Cathal O' Donnell regarding this. It was agreed that it be rolled out for HSE and DFB APs initially in order to limit the risk of liability. The Chair asked whether the service would be available for GPs. A discussion ensued outlining how GPs have traditionally sought advice directly from hospitals. The concept of extending the AP online advice, however could be explored to include GPs when the service bedded down. It was noted that PHECC supports this HSE initiative and agreed that information regarding the initiative be included in the AP CPG manual and field guide.

6. Ambulance Equipment Standards

Included in the papers was a discussion paper on ambulance equipment standards. PHECC propose that, based on the clinical levels on the register, to designate ambulances in terms of the clinical care available to the patient during transport. Ambulances would be designated as:

- EMT level ambulance
- Paramedic level ambulance
- Advanced Paramedic level ambulance

It was acknowledged that currently practitioners carry a full range of medications, as per the National Ambulance Standards (1995) equipment list, and many of these medications are outside the scope of practice of most of the practitioners involved. It was confirmed that this initiative would minimise waste, as medications were constantly going out of date and being disposed of.

It was agreed that ambulances did not need to carry equipment and /or medications that were outside the scope of practice of the specific practitioners on the ambulance.

Macartan Hughes stated that the NAS developed a new ambulance equipment list for their ambulances and offered to provide this list to PHECC.

The discussion concluded that it was too narrow to designate ambulances into these three categories, however all pre-hospital emergency care services should be designated according to the PHECC clinical level available. Such clinical level, however must have the equipment and medications available to perform fully within their scope of practice otherwise it cannot be specified at that clinical level.

7. A.O.B.

Cathal O' Donnell requested that MAG discuss the CPG for behavioural emergency, which has not yet been authorised within the HSE. It was agreed to table for discussion at a future meeting.

The next MAG meeting will be held in the PHECC office Naas, on Thursday 2nd June 2011, from 10.00am until 3.00pm.

The Chair thanked the group for their attendance.

There being no further business the meeting concluded.

Signed: _____

Date: _____

The Medical Advisory Group
Meeting Minutes 5th July 2011, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Niamh Collins
Mark Doyle
Stephen Cusack
Valerie Small
David Menzies
Peter O' Connor

Present

Geoff King (Director)
Brian Power
Marian Spence

Apologies

John O'Donnell
Sean Walsh
Cathal O'Donnell
David Janes
Gerry Bury
Lawrence Kenna
Macartan Hughes
Frank O' Malley
Sean O' Rourke
Conor Egleston
Brendan Whelan
Declan Lonergan

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. The scheduling of MAG meetings has proved problematic in so far as the timeframe between MAG and Council meetings causes administrative difficulties with producing Council papers in time. The Chair suggested as Council had scheduled meeting dates on the second Thursday of each month, that if MAG was scheduled two weeks prior to Council this difficulty would be resolved. This suggestion was accepted and the dates for future meetings (up to six months) will be sent to all members to enable them plan better.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 2nd June 2011 be approved.

Proposed: Valerie Small
Carried without dissent

Seconded: Niamh Collins

3. CPG Updates

3.1 CPGs with NaCl for update

Niamh Collins suggested that a standard approach be made to the administration of Magnesium Sulphate infusion i.e. dilute in 100 mL bag. This suggestion was agreed.

The following CPGs were discussed and changes were agreed:

- 3.1.1 Symptomatic Bradycardia – Paediatric (4/5/6.4.9)
Insert '0.9%' after NaCl
Change 'signs of poor perfusion' to 'signs of inadequate perfusion' and use the same list as outlined on Septic Shock (excluding tachycardia)
- 3.1.2 Allergic Reaction/Anaphylaxis – Adult (5/6.4.18)
Insert '0.9%' after NaCl
Change 'Reoccurs' to 'Rekurs'
- 3.1.3 Decompression Illness (DCI) (4/5/6.4.26)
Insert '0.9%' after NaCl
After 'Pain relieved required' add 'Nausea – yes/no – go to Nausea CPG'
- 3.1.4 Shock from Blood Loss – Adult (5/6.6.2)
Insert '0.9%' after NaCl
Delete the limb from 'no trauma' and combine both 'no trauma' & 'head injury with GCS > 8' into one limb to maintain Sys BP 90 – 100 mmHg.
- 3.1.5 Allergic Reaction/Anaphylaxis – Paediatric (5/6.7.8)
Insert '0.9%' after NaCl
- 3.1.6 Burns – Adult (4/5/6.6.4) Brian Power informed members that Paddy Burke had submitted updated burns CPGs for adult and paediatric which were included in the meeting papers.
Insert '0.9%' after NaCl
Simplify layout by reducing duplication
Change information box from 'minimum 15 minutes cooling of area is recommended' to 'should cool for another 10 minutes during packaging and transfer'
Remove restrictions to < 10% TBSA for burns gel. Add 'caution for > 10% TBSA'
- 3.1.7 Burns – Paediatric (4/5/6.7.16)
Insert '0.9%' after NaCl
Simplify layout by reducing duplication
Change information box from 'minimum 15 minutes cooling of area is recommended' to 'should cool for another 10 minutes during packaging and transfer'
Remove restrictions to < 10% TBSA for burns gel. Add 'caution for > 10% TBSA'
Delete 'or' after '>10% TBSA and'
- 3.1.8 Septic Shock – Paediatric (5/6.7.12)
Insert '0.9%' after NaCl
Delete 'oxygen therapy information box'
Correct spelling of 'Tachypnoea'
- 3.1.9 Septic Shock – Adult (5/6.4.21). Brian Power informed members that Denis Daly, AP intern, had submitted a proposal to amend the septic shock CPG which was included in the meeting papers.
Insert '0.9%' after NaCl
Delete 'Clinical signs of infection box'
Change 'Meningitis' to 'Meningococcal disease'

Resolution: That the CPGs with NaCl listed above be approved subject to agreed amendments.

Proposed: Peter O Connor
Carried without dissent

Seconded: David Menzies

3.2 CPGs for seizures

Following a request from Dr Sean Walsh for the Seizure CPGs be reviewed and a letter received from a Clare Doherty, Paramedic, outlining restrictions for Paramedics in relation to the treatment of seizures, the CPGs were redrafted and reviewed. The following changes were agreed:

3.2.1 Seizure/Convulsion – Adult (2/3.4.20)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

3.2.2 Seizure/Convulsion – Adult (4.4.20)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

3.2.3 Seizure/Convulsion – Adult (5/6.4.20)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

Authorise Paramedics to administer Midazolam IM, buccal and IN

Adjust the box on the left arm to read in the following order; Midazolam 10 mg buccal, Midazolam 5 mg IN, Midazolam 5 mg IM and Diazepam 10 mg PR.

Add text box 'Maximum two doses of anticonvulsant medication by Practitioner regardless of route'

3.2.4 Seizure/Convulsion – Paediatric (2/3.7.10)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

3.2.5 Seizure/Convulsion – Paediatric (4.7.10)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

3.2.6 Seizure/Convulsion – Paediatric (5/6.7.10)

In the information box re other causes of seizures delete 'tricyclic' and add 'alcohol/drug withdrawal'

Authorise Paramedics to administer Midazolam buccal and IN

Adjust the box on the left arm to read in the following order; Midazolam 0.5 mg/Kg buccal, Midazolam 0.2 mg/Kg IN, and Diazepam PR (with age appropriate doses).

In Diazepam PR change > 7 years to ≥ 8 years.

Add text box 'Maximum two doses of anticonvulsant medication by Practitioner regardless of route'

Add text box 'Do not exceed adult dose'

Resolution: That the CPGs for seizures listed above be approved subject to agreed amendments.

Proposed: Peter O Connor
Carried without dissent

Seconded: Niamh Collins

3.3. ACS CPG

The CPG, Cardiac Chest Pain – Acute Coronary Syndrome (5/6.4.16), having gone through many versions and agreed by Prof. Ciaran Daly on behalf of the ACS Programme was presented to the meeting for final sign off.

The following changes were agreed:

Add 'No contraindications' to the indications for thrombolysis information box

Add 'and thrombolysis indicated' to 'Symptoms \leq 3 hours'

Resolution: That the CPGs Cardiac Chest Pain – Acute Coronary Syndrome be approved subject to agreed amendments.

Proposed: Niamh Collins
Carried without dissent

Seconded: David Menzies

3.4 CPG Recommendations from Alan Watts

A document from Dr. Alan Watts outlining recommendations in relation to CPGs was included in the meeting papers. Members discussed the merits of these recommendations.

3.4.1 Advanced life support

Several items were included in this section including changing the paediatric energy for defibrillation from 2 J/Kg initially to 4 J/Kg. This suggestion had been previously agreed.

The major recommendation made under this section was to update the weight estimate formula from (age x 2)+8 to (age x 3)+7. A recent paper, published in the BMJ and distributed to all members prior to the meeting, supported this recommendation. Brian Power outlined figures from a small Irish study (unpublished) that concurred with these findings. It was agreed following deliberation that it was the best practice to change.

Resolution: That the (age x 3) +7 formula for paediatric weight estimation be adopted.

Proposed: Peter O Connor
Carried without dissent

Seconded: Mark Doyle

3.4.2 Respiratory Emergencies

Two recommendations were presented under this section:

Adopt the British Thoracic Society updated guidelines on asthma. As this issue had been recently debated and updated it was agreed that no changes were necessary.

Use equipment to assist difficult intubations. As this issue is currently being debated it was felt that it should be in the mix with overall intubation debate.

3.4.3 Seizure/Convulsions

The checking of blood glucose should be moved above treating an actively seizing patient on the CPGs. This was rejected by the meeting.

Clarification required in relation to IV and non IV routes for anticonvulsant medications. This was resolved by adding text box 'Maximum two doses of anticonvulsant medication by Practitioner regardless of route' to the CPG (see above)

3.4.4 Stroke

Remove 12 lead ECG from stroke CPG as it is a time critical event and it may cause unnecessary delay.

Resolution: Remove 12 lead ECG from stroke CPG.

Proposed: Stephen Cusack
Carried without dissent

Seconded: David Menzies

3.4.5 Spinal immobilisation CPGs

The recommendations led to a wide debate on the spinal immobilisation CPGs. It was pointed out that Paramedics were very cautious in relation to spinal rule out and Advanced Paramedics are only beginning to be comfortable with the process. It was agreed that the current CPGs were not as clear as they might be and while keeping the content intact they could be redrafted. Following discussion on the requirements and content of the spinal injury CPGs they were approved in principle. Niamh Collins agreed to send a redrafted version to Brian Power for consideration.

4. **Pre-Hospital Defibrillation Policy**

A draft pre-hospital defibrillation policy was included in papers for consideration. Brian Power outlined the rationale for this policy document. Policy items could be found in several locations including CPGs and minutes of MAG, however there was not one repository for all issues in relation to pre-hospital defibrillation. Following discussion it was agreed to recommend the pre-hospital defibrillation policy to Council subject to the following amendments:

Remove reference to 'PHECC chain of survival'

- 2.1 Delete 'The target for hands off time is maximum 10 seconds'. Replace with 'Minimise hands off time, absolute maximum 10 seconds'
- 3.2 Add 'to 200 joules' after '150 joules'
- 3.3 Delete 'increased to 200 joules'. Replace with 'as per manufacturer of defibrillator instructions'
- 4.2 Delete 'To minimise hands off time while maximizing safety the person performing chest compressions should press the defibrillation button'. Replace with 'The person pressing the defibrillation button is responsible for defibrillation safety'

Resolution: That the draft pre-hospital defibrillation policy be recommended to Council for approval.

Proposed: Niamh Collins
Carried without dissent

Seconded: Peter O Connor

5. Standard Radio Report to ED

Brian Power outlined that following consultation with practitioners on the PHECC Field Guide several practitioners requested that ASHICE or similar radio message be included in the next version. It was agreed that it was inappropriate to radio/phone Emergency Department (ED) for every patient being transported. When patients require urgent medical attention on arrival at the ED it is essential that an appropriate patient report precedes their arrival. The report needs to be clear and concise yet transfer all relevant information. Members discussed the 'ASHICE' mnemonic currently used when passing information to the EDs. It was agreed that the 'Age', 'Sex', 'History' and 'ETA' are standard and should be maintained. As outlined in the meeting papers there are varying interpretations of the 'I' and 'C' initials. The meeting suggested that 'I' should be 'illness/injury' and 'C' should be 'Condition causing concern'. It was suggested that as HSE and DFB are the primary users of the ASHICE report and that both Medical Directors should be consulted with a view to agree this matter. As there is a printing deadline the meeting agreed that following consultation with the Medical Directors the ASHICE report could be adopted.

Resolution: That ASHICE is the recommended reporting format for ED radio/phone reports and the mnemonic as outlined above, subject to consultation with the Medical Director/Advisor for HSE NAS and DFB, is adopted.

Proposed: Mark Doyle
Carried without dissent

Seconded: Peter O Connor

Post script

Following consultation with both Cathal O'Donnell and Pete O'Connor the following was agreed.

- A** — Age of patient
- S** — Sex of patient
- H** — History of event
- I** — Illness / injury
- C** — Condition (vital signs & reason for pre-alerting)
- E** — Estimated time of arrival

6. Medicinal products schedule update

This item was included for information. Brian Power thanked all who had submitted suggestions for inclusion on this list. The list will now be updated and submitted to the Department of Health to enable the seventh schedule be amended.

The Medical Advisory Group

Meeting Minutes 29th September 2011, 10.00am

PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Niamh Collins
Gerry Bury
Declan Lonergan
Sean O' Rourke
Sean Walsh
Lawrence Kenna
Peter O' Connor
Paul Lambert

Present

Geoff King (Director)
Brian Power
Marion O' Malley

Apologies

John O'Donnell
David Menzies
Cathal O'Donnell
David Janes
Macartan Hughes
Stephen Cusack
Frank O' Malley
Conor Egleston
Mark Doyle
Valerie Small
David McManus

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. It was agreed to take agenda item 3 – Pre-Hospital Early Warning Score off this meeting's agenda as general consensus could not be reached. This item will be put back on the agenda for the next meeting. The Director confirmed that the MEWS score would not be printed in the Field Guide or in the 3rd Edition CPGs, Version 2 as PHECC had to proceed to printing.

The Chair congratulated the Council Chairman, Mr Tom Mooney, and the PHECC team on the publication of the Strategic Plan and asked that the Director to convey the compliments of the group at the next Council meeting.

Lawrence Kenna sought clarification on why, under the Medical Advisory Group Terms of Reference published in the Strategic Plan, the position of Training and Development Officer is no longer captured. The Director explained that PHECC were trying to capture the new structure within the ambulance service and would welcome any suggestions made to revise the current wording which is under review at present.

Sean O' Rourke raised a concern that some practicing paramedics are not PHECC registered. The Director advised that the issue more relates to employment contracts within the HSE, but indicated that management and unions are in agreement that all practitioners should be registered.

2. Minutes and Matters Arising

Lawrence Kenna sought clarification regarding item 3.1.6 and it was confirmed that practitioners need to be wary of hypothermia in the patient, therefore, there was consensus to add 'caution for >10% TBSA'.

Lawrence Kenna had a concern over the use of Midazolam by paramedics for the seizure CPGs. The Director confirmed that this was not a knee jerk reaction from the group, and that Midazolam was considered in the context of its overall use.

Sean Walsh highlighted that many families have Midazolam as a rescue medication for seizures but stressed that with more than two doses you are risking side effects and doing little to help the seizure. Brian Power assured the group that the CPGs state a maximum of 2 doses.

Niamh Collins stated that there may be an operational issue with the safe storage of Midazolam and felt with the use of glass ampoules and concentration, there is potential for misuse and error. The Director confirmed that, as a service, there is no onus to use it.

Paul Lambert suggested that the group look into the Midazolam presentation as he felt that control may be an issue for DFB.

The Director stressed that, while the discussion regarding the use of Midazolam is healthy, there was agreement at the last MAG meeting to amend the seizure CPGs and that decision would not be reversed. He acknowledged that it was very positive that seizures can now be treated pre-hospital and that paramedics are in a position to improve their skill set.

It was noted that Lawrence Kenna expressed his frustration that, in his absence, at the last meeting when very few operational people were present, a key decision was made. The Director, again, confirmed that there was general consensus before the amendments to the CPGs were approved.

Sean Walsh raised a concern about the lack of clinical audit and the Director confirmed that Mark Doyle, as Deputy Medical Director, NAS, has a brief on clinical audit and also indicated that PHECC will give serious consideration to this issue, now that the OHCAR project has been integrated into the NAS.

Resolution: That the minutes from the Medical Advisory Group meeting of 5th July 2011 be approved.

Proposed: Niamh Collins
Carried without dissent

Seconded: Martin O' Reilly

3. Pre-Hospital Early Warning Score

It was agreed that this agenda item be deferred to the next meeting.

4. CPGs

- Proposal: - The reduction of the painful lateral patellar dislocation

Included in the papers was a proposal to introduce a CPG to facilitate Advanced Paramedics/Paramedics in the reduction of a painful laterally dislocated patella and Brian Power sought consensus from the group prior to drafting a new CPG. Niamh Collins suggested that it be looked at in the context of including in the CPG for Limb Fractures but the Director indicated that it would be hard to put into practice if a specific CPG was not created. The Chair felt that if an AP/P was able to achieve pre-hospital reduction of the laterally dislocated patella, then it was worth considering, and there was general agreement that a draft CPG be brought back to the group at a future meeting.

Gerry Bury informed the group that, when producing CPGs, there are training issues that need to be considered and recognised institutions will have to look at how they can systematically train practitioners and ensure their ongoing competency.

- Updated and new CPGs for responders

The Burns CPG, at responder level, was included in the papers and Brian Power sought approval to amend the GPG to make consistent with the Burns CPG at AP/P and EMT level. The following changes were agreed:

- 'Remove burned clothing (unless stuck) & jewellery' to read 'Remove burnt clothing (unless stuck) & jewellery'
- Add 'Prevent chilling' prior to 'Monitor body temperature'

Resolution: That CPG 2/3/6.4 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Sean O' Rourke
Carried without dissent

Seconded: Declan Lonergan

A number of draft CPGs at responder level were included in the papers for initial review. These CPGs are Anaphylaxis – Adult, Anaphylaxis – Paediatric, Poisons, External Haemorrhage, Soft Tissue Injury and Heat Related Illnesses. Brian Power explained that these CPGs will go through the Delphi process prior to seeking MAG approval but requested the opinion of the group at this time.

Anaphylaxis Adult and Paediatric

It was agreed to redraft both CPGs with the following amendments:

- Make the 'Respiratory distress' loop secondary to collapsed state
- After 'Oxygen therapy insert ' Collapsed state'
- Include 'difficulty breathing' and 'diminished consciousness' on CPG
- Record ' Patient's name, Responder's name and Doctor's name on CPG

Poisons

The following suggestions were made:

- After 'Paraquat' insert '(weed killer)'
- Include text box ' if suspected tablet overdose locate tablet container and hand it over to appropriate practitioner'

External Haemorrhage

There were no amendments suggested for this CPG.

Soft Tissue Injury

The following suggestions were made:

- Delete the word 'subluxation'
- 'Open wound' to be replaced with 'Open wound present?'
- Amend 'Unable to weight bear' to read 'Unable to weight bear or use limb'

A discussion took place on the value of ice for soft tissue injuries.

Heat Related Illnesses

The following suggestions were made:

- Remove 'Check blood glucose'
- List cooling processes on CPG
- 'Exercise related hypohydration should be treated with an oral carbohydrate/electrolyte solution' to be replaced with ' Exercise related dehydration should be treated with oral fluids'

5. Transport Medicine Submission, for information

The Transport Medicine Submission was included in the meeting papers for information and the Director briefly outlined the proposal. The project aims to develop, pilot and implement a training/induction course in Transport Medicine for adult high acuity patient Retrieval/Transfers and should funding be granted PHECC will contribute matching funds. If successful, the standards and course developed would be accredited by PHECC's Accreditation Committee, PHECC Council and the College of Anaesthetists. There was unanimous support from the group for this initiative.

6. AOB

The next meeting will take place on Thursday 27th October. Please note, the scheduled November meeting date has been changed from Thursday 24th November to Tuesday 22nd November. The Chair thanked members for their attendance. There being no further business the meeting concluded.

Signed: _____

Date: _____

The Medical Advisory Group
Meeting Minutes 27th October 2011, 10.00am
PHECC Office, Naas, Co. Kildare

In Attendance

Zelie Gaffney (Chair)
Martin O' Reilly
Niamh Collins
Cathal O Donnell
Declan Lonergan
Sean O' Rourke
Sean Walsh
Lawrence Kenna
Peter O' Connor
Paul Lambert
David Menzies
Mark Doyle

Present

Geoff King (Director)
Brian Power
Marion O' Malley

Apologies

Stephen Cusack
Gerry Bury
Conor Egleston
Macartan Hughes
Valerie Small
Frank O' Malley

1. Chair's Business

The Chair opened the meeting by thanking members for their attendance and apologies were acknowledged. The Chair informed the group that Professor Ronan O' Sullivan and Dr Adrian Murphy would make a presentation titled 'Current and Future Trends in Pre-hospital Paediatric Analgesia', under agenda item No. 3.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 29th September 2011 be approved.

Proposed: Peter O' Connor
Carried without dissent

Seconded: Sean O' Rourke

3. Prof Ronan O' Sullivan/Dr Adrian Murphy – Presentation: Pre-hospital analgesia in children in Ireland

Prof O' Sullivan and Dr Murphy were welcomed by the group and Dr Murphy gave a brief presentation outlining the main objectives of the project and sought advice and feedback from the group. The ultimate aim of this project is to improve the pre-hospital care of acute pain in children when treated by

ambulance practitioners. It is hoped that during the development of the trial, that robust clinical practice guidelines will be produced for ambulance practitioners in the management of acute pain in children, with particular reference to intranasal fentanyl as a safe and effective alternative to intravenous morphine.

Initially, a prospective cross-sectional study will be undertaken over a 12 month period, in 5 emergency departments throughout the country, where a designated triage nurse will complete a patient case report form following handover from the ambulance practitioner. PCR data will be used to record patient demographics.

The study will also describe the opinions and attitudes of experienced APs relating to managing acute pain in children prior to ED arrival, and it is envisaged that a pre-hospital paediatric analgesia training programme for APs be implemented.

One of the main aims of the project is to present evidence base for the use of intranasal fentanyl in the acute management of pain in children, to develop CPGs to support this and to conduct a study of all paediatric patients treated by APs under the new CPGs for paediatric pain management. Prof O' Sullivan sought the support of the Medical Advisory Group in the development of these CPGs.

Following some discussion it was agreed that PHECC will:

- Develop a CPG to support the research trial and application to the Irish Medicines Board
- Include intranasal fentanyl in the Medications Schedule
- Draw up an interim directive to allow practitioners administer intranasal fentanyl
- Assist in the development of an e-learning package for practitioners
- Include information relating to the project in its Newsletter 'PHECC Voice'

Resolution: That the Medical Advisory Group supports the research framework presented by Professor O' Sullivan and Dr Murphy relating to managing acute pain in children.

Proposed: Mark Doyle
Carried without dissent

Seconded: David Menzies

4. CPGs

ACS CPG

The Cardiac Chest Pain – Acute Coronary Syndrome CPG was included in the papers for approval prior to ratification by Council. It follows feedback from John Dowling, Medical Practitioner.

The following changes were agreed:

- Include an 'instruction box' to read ' If patient is already on Clopidogrel do not administer it'
- Include an 'MP flag' beside No. 3 in the 'Indication for Thrombolysis' instruction box

- Include an additional medication tube for medical practitioners with 'Enoxaparin 30 mg IV (> 75 Yrs: Enoxaparin 0.75 mg/kg SC)'

Resolution: That CPG 5/6.4.16 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Peter O' Connor

Responder CPGs

A number of draft CPGs at responder level were included in the papers for approval following a Delphi process, results of which were also included. Brian Power sought a recommendation from the group prior to approval by Council. These CPGs were Heat Related Illnesses, Soft Tissue Injury, External Haemorrhage, Anaphylaxis – Adult and Anaphylaxis – Paediatric, Poisons.

Draft CPG 2/3.4.31 - Heat Related Illnesses

The following changes were agreed:

- 'Give fluids to drink' to read 'Give cool fluids to drink'
- 'should be treated with an oral fluids' to read 'should be treated with oral fluids'
- Mark Doyle to determine fluid volume and Brian Power to include in instruction box

Resolution: That CPG 2/3.4.31 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Paul Lambert

Draft CPG 2/3.6.10 – Soft Tissue Injury

Cathal O' Donnell expressed his opposition to formalising CPGs at responder level where there is a treat and discharge option. He stated that there is disparity between practitioners and responders based on these draft CPGs. Brian Power indicated that these CPGs are being produced as there is no current guidelines in place and responders are taking their guideline from whatever text book they read. The Director highlighted that PHECC currently provide structure and support to large volumes of work at responder level and had hoped that these CPGs would assist responders. After some discussion it was agreed that the MAG address 'Treat & Discharge' and 'Treat & Referral' at practitioner level before concentrating on responder level. This CPG will be brought back to MAG where the guidance will lean towards what the appropriate action to take should be, and will not include 'discharge' in the CPG.

Draft CPG 2/3.6.1 – External Haemorrhage

The following was agreed:

- Remove the left arm of the CPG relating to 'clean wound', 'apply sterile dressing' and 'follow organisational protocols for minor injuries'

- Move phone symbol down to 'clinical signs of shock'
- 'Apply additional dressing(s)' to read 'Apply additional pressure dressing(s)'

Resolution: That CPG 2/3.6.1 be recommended to Council for approval, subject to the changes outlined above.

Proposed: Sean O' Rourke
Carried without dissent

Seconded: Mark Doyle

Draft CPG 2/3.4.23 – Poisons

Cathal O' Donnell believes that this CPG is not appropriate at EFR level, with the exception of fire fighters. He felt that due to the complexity of the CPG it should be at EMT level as a minimum. It was suggested that Paraquat be removed from the CPG and also that the CPG be split into 3 individual CPGs. The revisions to this CPG will be brought back to MAG for approval.

Draft CPG 2/3.4.18 – Anaphylaxis – Adult and draft CPG 2/3.7.8 Anaphylaxis – Paediatric (≤ 13 years)

A discussion ensued relating to the definition of Anaphylaxis. Mark Doyle felt that the CPG should indicate 'skin changes' when identifying anaphylaxis. It was agreed that these CPGs be reviewed and brought back to MAG for approval.

5. Pre-hospital Early Warning Score

The HSE Acute Medicine Programme has introduced a National Early Warning Score system which is being implemented in hospitals and will be known as NEWS. This NEWS and the PHECC MEWS are out of sync and the Director felt that this may lead to mis-communication. It was proposed that, where possible, PHECC use the same approach and parameters as the national standard, and this would help avoid confusion and reinforce the current impetus of national consensus building. It would also provide a data convention that will allow research to establish the potential role of EWS in pre-hospital. A paper detailing PHECC's recommendations was included in the meeting papers, along with Delphi responses from the group. The Director apologised if any members felt pressured into making a decision regarding this agenda item at previous meetings. He confirmed that any pressure applied was as a result of time constraints in the publishing of the Field Guide and the CPGs. The Director suggested that MAG research the merits in moving to the same parameters as the National Early Warning Score system. Brian Power informed the group that currently the PHECC MEWS is currently a discretionary used CPG tool. Declan Lonergan stated that if it is not a requirement to take a MEWS score, practitioners won't use it. David Menzies commented that all data is currently being captured in the PCR, with the exception of urinary output. Cathal O' Donnell raised a concern that it may be used to determine the destination of a patient.

Some of the suggestions put forward for the use of the MEWS were:

- Remove completely from PHECC publications
- Allow in PCR/ePCR to measure parameters to allow it be collected and used proactively to lead research and have it validated scientifically
- Update PHECC MEWS to reflect NEWS parameters

It was agreed that the MEWS would not be printed in CPGs or Field Guide and that it will continue to be captured in the PCR/ePCR, with a view to using the data collected to proactively lead research into the validity of the Pre-Hospital Early Warning Score.

Resolution: That the Medical Advisory Group undertakes to conduct research to establish the potential role of EWS in pre-hospital.

Proposed: Peter O' Connor
Carried without dissent

Seconded: Declan Lonergan

6. HSE Emergency Asthma Guideline, for information

Included in the papers for information was the HSE Emergency Asthma Guideline. The guidelines were generally welcomed although some minor anomalies were identified and Brian Power agreed to highlight these to the HSE. Sean Walsh specifically highlighted that for severe asthma the CPGs direct practitioners to give 2 puffs of Salbutamol while the asthma guideline states that four puffs be given. It was also suggested by the group that the audit form is not relevant to PHECC as the information requested applies only when the patient is admitted.

7. AOB

Cathal O' Donnell requested that the group discuss the development of a CPG to deal with behavioural emergency. He previously raised this issue at the March 2011 meeting. It was agreed to include as an agenda item at the next meeting.

Cathal O' Donnell also requested that the subject of post graduate interns be discussed in detail at a future MAG meeting. An issue arose following an incident where an EMT and a post graduate intern attended a call together and it was thought prudent to discuss their scope of practice particularly crewing arrangements. The Director advised that currently PHECC guidelines allow a post graduate intern work with either an EMT or an under graduate intern. After a brief discussion it was agreed that the group discuss this matter at the next MAG with a view to defining the word 'intern' and giving guidance on their role and scope of practice.

The next meeting will take place on Tuesday 22nd November. The Chair thanked members for their attendance. There being no further business the meeting concluded.

Signed: _____

Date: _____

7. AOB

Martin O'Reilly sought clarification on 'acute alcoholism' as a contraindication for morphine. It was agreed that the term was too vague in relation to the administration of morphine.

Resolution:

That 'acute alcoholism' be deleted as a contraindication of morphine in the medication formulary.

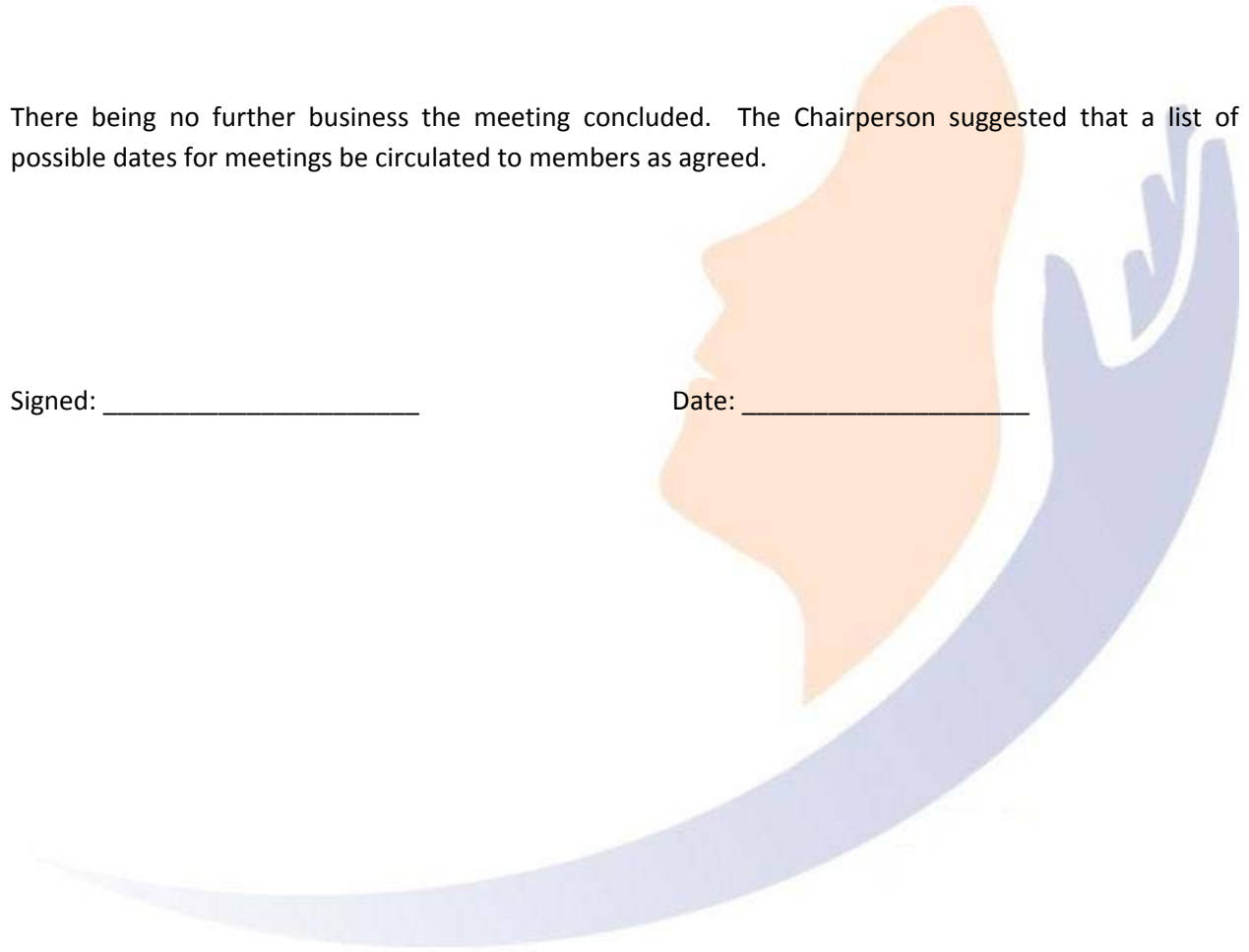
Proposed: David Menzies
Carried without dissent

Seconded: Mark Doyle

There being no further business the meeting concluded. The Chairperson suggested that a list of possible dates for meetings be circulated to members as agreed.

Signed: _____

Date: _____



The Medical Advisory Group

Minutes 16th December 2010, 10.30am

PHECC Office, Naas, Co. Kildare

In Attendance

Cathal O'Donnell (Chair)
David Janes
Brendan Whelan
Niamh Collins
David Menzies
Mark Doyle
Peter O'Connor
Sean Walsh
Valerie Small
Lawrence Kenna
Gerry Bury
Declan Lonergan
Macartan Hughes
Frank O' Malley

Present

Geoff King (Director)
Brian Power
Marion O' Malley

Apologies

Michael Garry
Stephen Cusack
John O'Donnell
Zelie Gaffney
Conor Egleston

1. Chair's Business

The Chair welcomed everybody and apologies were acknowledged. Due to the impending bad weather the Chair suggested that the meeting be concluded at 3pm and that agenda items 3 & 4 be addressed as priority. The remaining items are to be deferred to the next meeting.

The Chair announced that he has been appointed Medical Director of the National Ambulance Service and that he was standing down as Chair of MAG, following this meeting, due to potential conflict of interest. He acknowledged the support of the group and the staff of PHECC over the past two years.

David Janes wished the Chair well in his new post. The Director advised that PHECC are currently reviewing MAG membership, as historically a member of Council was nominated as Chair. He also wished the Chair well and looks forward to working with him in his new role. The Chair will stay on as a member of the group. David Janes offered to chair the next meeting pending the appointment of a new Chair.

The draft 3rd Edition PCR was tabled. Jacqueline Egan detailed the changes to the PCR following public consultation, feedback and internal review, and sought approval from the group.

Resolution: That the 3rd Edition PCR be approved.

Proposed: David Janes
Carried without dissent

Seconded: Macartan Hughes

2. Minutes and Matters Arising

It was omitted from the November minutes that Frank O' Malley sent his apologies.

Niamh Collins asked if the MAG should revise the paediatric rectal dose of paracetamol. It was agreed that Sean Walsh and Brian Power address the recommendations.

Gerry Bury referred to agenda item 7 – *ACS changes & 12 lead ECG interpretation* and felt that Prof Kieran Daly was not advocating the expansion of Primary PCI facilities as the minutes reflect. It was agreed to re-word the sentence to read:

- Prof Kieran Daly's direction that the ACS programme will be advising the re-organisation of Primary PCI facilities and his research indicating that the best outcome for patients are achieved by accessing PPCI facilities directly rather than in field or non PCI centre thrombolysis regardless of timeframe except in a very small subject group (young male, < 65 years, with large MI who can receive thrombolytic agent within 2 hours of onset of symptoms).

Under AOB, the issue of the inclusion of nebulised adrenaline for paediatric stridor, raised by Sean Walsh, will be addressed at the next meeting.

Sean Walsh indicated that Crumlin Hospital were bringing out their medication formulary as an APP and asked if ambulances had the relevant technology for access to the formulary. Brian Power advised that PHECC are currently publishing a field guide for practitioners and that a concern in using another would be the calculation of doses. Niamh Collins raised the issue of accountability surrounding the process for informing practitioners of any changes made. Brian Power suggested having a linked reference to the APP and the Chair suggested that Macartan Hughes, Brian Power, Sean Walsh and he discuss the matter further in 2011.

The item on collaborative practice will be discussed at a further meeting.

Resolution: That the minutes from the Medical Advisory Group meeting of 2nd/3rd November 2010 be approved.

Proposed: Macartan Hughes
Carried without dissent

Seconded: Valerie Small

4. ACS changes

The Chair explained that following feedback from the group a letter was drafted and sent to Robert Morton, Una Geary and Kieran Daly, seeking their advice regarding the redrafted ACS CPG. The letter detailed the implications of the redrafted CPG. The Chair thanked members for their feedback. David Janes expressed his dissatisfaction with some of the contents, however, the Chair indicated that the letter was drafted following majority consensus at the last MAG meeting and that the redrafted CPG is currently for discussion purposes only; the existing CPG is still in use.

Further concerns were raised by David Janes regarding the role of the MAG in setting the standards versus the day to day operations of the EMS. The Chair emphasised that ultimately, all MAG decisions have to be based on improving patient care. The Director advised that PHECC needs to sign off on best practice and that it is of great significance that the relevant people can now contribute to the ACS debate. Macartan Hughes felt that the role of the MAG was in the development the CPG's and that operational matters should be dealt with by the Clinical Care Committee. After much discussion the Chair suggested that the group await feedback from the relevant parties before getting into the detail of the redrafted ACS CPG.

Niamh Collins recommended that the MAG formally ask the ACS Programme for clarification regarding the use of clopidogrel versus prasugrel.

The Director informed the group that the Department of Health & Children officially notified the office that the matter of subsuming PHECC into the Health & Social Care Professionals Council (HSCPC) will be kept under review and will be re-visited in three years time.

Gerry Bury raised a concern regarding the acquisition of 12 lead ECG units and Macartan Hughes indicated that the HSE have purchased 50 machines and are currently in negotiations regarding the delivery and implementation of them.

3. ILCOR

In the meeting papers each treatment recommendation of the 2010 ILCOR guidelines was detailed on a table with comparisons of the AHA and ERC guidelines, along with PHECC's recommendations for change, where applicable.

Brian Power explained that he sought approval of the broad principles of the recommendations and that the specific details would be dealt with at a later meeting when the relevant CPG's are redrafted for review.

The following recommendations were agreed:

Part 5 – Adult Basic Life Support

Reference	Recommendations
A BLS 1 Pulse Check, Breathing Assessment, Signs of Circulation	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>
A BLS 2	<p>Practitioners Change initial sequence to CAB De emphasise pulse checks for cardiac arrest recognition</p> <p>Responders Change initial sequence to CAB</p>
A BLS 3 Etiology of Cardiac Arrest	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 4 Check for Circulation During BLS	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 5 Method to Locate Hand Position	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 6 Chest Compression Rate	<p>Practitioners Reinforce minimum compression rate of a minimum of 100 per minute and a maximum of 120 per minute</p> <p>Responders Reinforce minimum compression rate of a minimum of 100 per minute and a maximum of 120 per minute</p>
A BLS 7 Chest Compression Depth	<p>Practitioners Reinforce compression depth of 5 cm</p> <p>Responders Reinforce compression depth of 5 cm</p>
A BLS 8 Chest Decompression (recoil)	<p>Practitioners No change</p> <p>Responders No change</p>

<p>A BLS 9 Firm Surface for Chest Compressions</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 10 Feedback for Chest Compression Quality</p>	<p>Practitioners Clinical leaders should monitor quality of CPR during cardiac arrest.</p> <p>Responders No change</p>
<p>A BLS 11 “Cough” CPR</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 12 Precordial Thump</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 13 Fist Pacing</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 14 Airway, Opening the Airway</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 15 Passive Ventilation</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 16 Foreign-Body Airway Obstruction</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 17 Tidal Volumes and Ventilation Rates</p>	<p>Practitioners Reinforce inspiration volume of 500 to 600 mL</p> <p>Responders Reinforce inspiration volume of 500 to 600 mL</p>
<p>A BLS 18 Effect of Interruptions on Delivery of chest Compressions</p>	<p>Practitioners Reinforce minimising interruptions of chest compressions during resuscitation. Moving a patient in cardiac arrest should be a planned and co-ordinated process.</p>

	<p>Responders Reinforce minimising interruptions of chest compressions during resuscitation</p>
A BLS 19 Use of Filtering Devices for Rhythm Analysis During CPR	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 20 Compression-Ventilation Ratio During CPR	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 21 Chest Compression–Only CPR	<p>Practitioners No change</p> <p>Responders Add text box to CPG advising to perform compression only CPR if unable or unwilling to ventilate</p>
A BLS 22 Cervical Spine Injury	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 23 Emergency Medical Services (EMS) Systems Dispatcher Recognition of Cardiac Arrest	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>
A BLS 24 Dispatcher Instruction in CPR	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers No change</p>
A BLS 25 Risks to Victim	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>

Resolution: That the MAG approve PHECC recommendations relating to Part 5 – Adult Basic Life Support.

Proposed: Peter O’ Connor
Carried without dissent

Seconded: Macartan Hughes

Part 6: Defibrillation

D1 CPR Before Defibrillation	Practitioners Apply defibrillator pads as soon as possible and analyse Responders No change
D2 Self-Adhesive Defibrillation Pads Compared With Paddles	Practitioners No change Responders No change
D3 Placement of Paddles/Pads	Practitioners No change Responders No change
D4 Size of Paddles/Pads	Practitioners No change Responders No change
D5 Composition of Conductive Material	Practitioners No change Responders No change
D6 Biphasic Compared With Monophasic Defibrillation Waveform	Practitioners No change Responders No change
D7 Multiphasic Compared With Biphasic Defibrillation Waveform	Practitioners No change Responders No change
D8 Waveforms, Energy Levels, and Myocardial Damage	Practitioners No change Responders No change
D9 One-Shock Compared With 3-Stacked Shock Protocols	Practitioners No change Responders No change
D10 Fixed Versus Escalating Defibrillation Energy Protocol	Practitioners No change Responders No change
D11 Shock Using Manual Versus Semi-Automatic Mode	Practitioners Consider changing to manual mode for Paramedics to improve ‘hands off’ time for 2 nd and subsequent shocks. Responders No change
D11 Cardioversion Strategy in Atrial Fibrillation	Practitioners No change Responders No change
D12 Pacing (eg, Transcutaneous [TC], Transvenous [TV], Needle, and Fist)	Practitioners No change Responders No change
D13 Implantable Cardioverter	Practitioners No change

Defibrillator (ICD) or Pacemaker	Responders No change
D14 Predicting Success of Defibrillation and Outcome (VF Waveform Analysis)	Practitioners No change Responders No change
D15 Defibrillation in the Immediate Vicinity of Supplementary Oxygen	Practitioners No change Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 6 – Defibrillation.

Proposed: Lawrence Kenna
Carried without dissent

Seconded: Niamh Collins

Part7: CPR Techniques and Devices

T&D 1 Interposed Abdominal Compression (IAC)-CPR	Practitioners No change Responders No change
T&D 2 Active Compression-Decompression (ACD)-CPR	Practitioners No change Responders No change
T&D 3 Open-Chest CPR	Practitioners No change Responders No change
T&D 4 Load Distributing Band (LDB)–CPR	Practitioners No change Responders No change
T&D 5 Mechanical (Piston) CPR	Practitioners No change Responders No change
T&D 6 Lund University Cardiac Arrest	Practitioners No change Responders No change
T&D 7 Impedance Threshold Device (ITD)	Practitioners No change Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 7 – CPR Techniques and Devices.

Proposed: Declan Lonergan
Carried without dissent

Seconded: David Janes

Part 8: Advanced Life Support

ALS 1 Oropharyngeal and Nasopharyngeal Airways	Practitioners No change Responders No change
ALS 2 Cricoid Pressure	Practitioners No change Responders No change
ALS 3 Timing of Advanced Airway Placement	Practitioners No change Responders No change
ALS 4 Advanced Airway Versus Ventilation With Bag-Mask	Practitioners Introduce uncuffed supraglottic airway for EMT level Responders Introduce uncuffed supraglottic airway for CFR advanced level
ALS 5 Tracheal Intubation Versus the Combitube/Laryngeal Mask Airway	Practitioners No change Responders No change
ALS 6 Exhaled Carbon Dioxide Detection and Esophageal Detection Devices	Practitioners Introduce waveform capnography for Advanced Paramedic level Responders No change
ALS 7 Thoracic Impedance	Practitioners No change Responders No change
ALS 8 Supplemental Oxygen: 100% vs Titration	Practitioners No change Responders No change
ALS 9 Passive Oxygen vs Positive Pressure Oxygen During CPR	Practitioners No change Responders No change
ALS 10 Monitoring Ventilatory Parameters During CPR	Practitioners No change Responders No change
ALS 11 Monitoring Physiological Parameters During CPR	Practitioners Introduce waveform capnography for Advanced Paramedic level Responders No change
ALS 12 Automatic Ventilators vs Manual Ventilation During CPR	Practitioners No change Responders No change
ALS 13 Timing of Drug Delivery	Practitioners Administer Epinephrine after 1 st shock and before 4 th shock for VF/VT Responders No change
ALS 14 Vasopressors	Practitioners No change Responders No change
ALS 15 Atropine	Practitioners Removed Atropine for asystolic and PEA arrests Responders No change
ALS 16 Lidocaine, Procainamide,	Practitioners No change

Amiodarone, Bretylium, Magnesium	Responders No change
ALS 17 Calcium	Practitioners No change Responders No change
ALS 18 Steroid and Hormonal Therapy	Practitioners No change Responders No change
ALS 19 Buffers	Practitioners Consider Sodium bicarbonate for APs if tricyclic antidepressant overdose is the cause of the arrest. Administer 50 mmol bolus Responders No change
ALS 20 Fibrinolytics	Practitioners No change Responders No change
ALS 21 Chilled Fluid vs Room-Temperature Fluid	Practitioners Consider fluid challenge by APs for asystolic & PEA arrests Responders No change
ALS 22 Extracorporeal Circulatory Support During Cardiac Arrest	Practitioners No change Responders No change
ALS 23 Narrow-Complex Tachycardia (Excluding Atrial Fibrillation)	Practitioners Introduce vagal manoeuvres for APs Responders No change
ALS 24 Atrial Fibrillation	Practitioners No change Responders No change
ALS 25 Monomorphic VT	Practitioners Introduce Amiodarone for VT for APs Responders No change
ALS 26 Undifferentiated Regular Stable Wide-Complex Tachycardia	Practitioners No change Responders No change
ALS 27 Polymorphic Wide-Complex Tachycardia	Practitioners No change Responders No change
ALS 28 Bradycardia	Practitioners No change Responders No change
ALS 29 Cardiac Arrest Caused by Avalanche	Practitioners No change Responders No change
ALS 30 Pregnancy	Practitioners Reinforce left lateral tilt. Responders Reinforce left lateral tilt.
ALS 31 Cardiac Arrest in Morbid Obesity	Practitioners No change Responders No change
ALS 32 Cardiac Arrest Caused by Asthma	Practitioners No change

	Responders No change
ALS 33 Cardiac Arrest Caused by Anaphylaxis	Practitioners No change Responders No change
ALS 34 Cardiac Arrest Caused by Local Anesthetic	Practitioners No change Responders No change
ALS 35 Benzodiazepine Toxicity	Practitioners No change Responders No change
ALS 36 β-Blocker Toxicity	Practitioners No change Responders No change
ALS 37 Calcium Channel Blocker Toxicity	Practitioners No change Responders No change
ALS 38 Carbon Monoxide Toxicity	Practitioners No change Responders No change
ALS 39 Cocaine Toxicity	Practitioners No change Responders No change
ALS 40 Cyanide Toxicity	Practitioners No change Responders No change
ALS 41 Tricyclic Antidepressant Toxicity	Practitioners Introduce sodium bicarbonate for cardiac arrest caused by tricyclic antidepressant overdose for APs. Administer 50 mmol bolus Responders No change
ALS 42 Digoxin Toxicity	Practitioners No change Responders No change
ALS 43 Opioid Toxicity	Practitioners No change Responders No change
ALS 44 Cardiac Arrest During Coronary Catheterization	Practitioners No change Responders No change
ALS 45 Cardiac Arrest After Open or Closed Heart Surgery	Practitioners No change Responders No change
ALS 46 Cardiac Arrest Caused by Cardiac Tamponade	Practitioners No change Responders No change
ALS 47 Cardiac Arrest Caused by Pulmonary Embolus	Practitioners No change Responders No change
ALS 48 Cardiac Arrest Caused by Electrolyte Disorders	Practitioners No change Responders No change
ALS 49 Ultrasound During Cardiac Arrest	Practitioners No change

	Responders No change
ALS 50 Postresuscitation Treatment Protocol	Practitioners ROSC patients with APs in attendance should be transported to hospitals that have appropriate facilities to manage ROSC. Responders No change
ALS 51 Pulmonary Embolism	Practitioners No change Responders No change
ALS 52 Ventilation	Practitioners No change Responders No change
ALS 52 Controlled Oxygenation	Practitioners Titrate O ₂ to 94 – 98% following ROSC for Paramedics and Advanced Paramedics Responders No change
ALS 53 Fluid Therapy	Practitioners Consider fluid challenge if the patient is hypotensive following ROSC for APs Responders No change
ALS 54 Hemodynamic Optimization	Practitioners Consider fluid challenge if the patient is hypotensive following ROSC for APs Responders No change
ALS 55 Cardioactive Drugs	Practitioners No change Responders No change
ALS 56 Antiarrhythmic Drugs	Practitioners No change Responders No change
ALS 57 Mechanical Circulatory Support	Practitioners No change Responders No change
ALS 58 Prevention and Treatment of Hyperthermia	Practitioners Consider active cooling Responders Consider active cooling.
ALS 59 Therapeutic Hypothermia	Practitioners Active cooling following ROSC, at U on AVPU scale, regardless of arrest rhythm. Responders Consider active cooling.
ALS 60 Seizure Control	Practitioners No change Responders No change
ALS 61 Blood Glucose Control	Practitioners EMTs to check blood glucose following ROSC Responders No change
ALS 62 Steroid Therapy	Practitioners No change Responders No change
ALS 63 Hemofiltration	Practitioners No change

The Medical Advisory Group

Minutes 16th December 2010, 10.30am

PHECC Office, Naas, Co. Kildare

In Attendance

Cathal O'Donnell (Chair)
David Janes
Brendan Whelan
Niamh Collins
David Menzies
Mark Doyle
Peter O'Connor
Sean Walsh
Valerie Small
Lawrence Kenna
Gerry Bury
Declan Lonergan
Macartan Hughes
Frank O' Malley

Present

Geoff King (Director)
Brian Power
Marion O' Malley

Apologies

Michael Garry
Stephen Cusack
John O'Donnell
Zelie Gaffney
Conor Egleston

1. Chair's Business

The Chair welcomed everybody and apologies were acknowledged. Due to the impending bad weather the Chair suggested that the meeting be concluded at 3pm and that agenda items 3 & 4 be addressed as priority. The remaining items are to be deferred to the next meeting.

The Chair announced that he has been appointed Medical Director of the National Ambulance Service and that he was standing down as Chair of MAG, following this meeting, due to potential conflict of interest. He acknowledged the support of the group and the staff of PHECC over the past two years.

David Janes wished the Chair well in his new post. The Director advised that PHECC are currently reviewing MAG membership, as historically a member of Council was nominated as Chair. He also wished the Chair well and looks forward to working with him in his new role. The Chair will stay on as a member of the group. David Janes offered to chair the next meeting pending the appointment of a new Chair.

The draft 3rd Edition PCR was tabled. Jacqueline Egan detailed the changes to the PCR following public consultation, feedback and internal review, and sought approval from the group.

Resolution: That the 3rd Edition PCR be approved.

Proposed: David Janes
Carried without dissent

Seconded: Macartan Hughes

2. Minutes and Matters Arising

It was omitted from the November minutes that Frank O' Malley sent his apologies.

Niamh Collins asked if the MAG should revise the paediatric rectal dose of paracetamol. It was agreed that Sean Walsh and Brian Power address the recommendations.

Gerry Bury referred to agenda item 7 – *ACS changes & 12 lead ECG interpretation* and felt that Prof Kieran Daly was not advocating the expansion of Primary PCI facilities as the minutes reflect. It was agreed to re-word the sentence to read:

- Prof Kieran Daly's direction that the ACS programme will be advising the re-organisation of Primary PCI facilities and his research indicating that the best outcome for patients are achieved by accessing PPCI facilities directly rather than in field or non PCI centre thrombolysis regardless of timeframe except in a very small subject group (young male, < 65 years, with large MI who can receive thrombolytic agent within 2 hours of onset of symptoms).

Under AOB, the issue of the inclusion of nebulised adrenaline for paediatric stridor, raised by Sean Walsh, will be addressed at the next meeting.

Sean Walsh indicated that Crumlin Hospital were bringing out their medication formulary as an APP and asked if ambulances had the relevant technology for access to the formulary. Brian Power advised that PHECC are currently publishing a field guide for practitioners and that a concern in using another would be the calculation of doses. Niamh Collins raised the issue of accountability surrounding the process for informing practitioners of any changes made. Brian Power suggested having a linked reference to the APP and the Chair suggested that Macartan Hughes, Brian Power, Sean Walsh and he discuss the matter further in 2011.

The item on collaborative practice will be discussed at a further meeting.

Resolution: That the minutes from the Medical Advisory Group meeting of 2nd/3rd November 2010 be approved.

Proposed: Macartan Hughes
Carried without dissent

Seconded: Valerie Small

4. ACS changes

The Chair explained that following feedback from the group a letter was drafted and sent to Robert Morton, Una Geary and Kieran Daly, seeking their advice regarding the redrafted ACS CPG. The letter detailed the implications of the redrafted CPG. The Chair thanked members for their feedback. David Janes expressed his dissatisfaction with some of the contents, however, the Chair indicated that the letter was drafted following majority consensus at the last MAG meeting and that the redrafted CPG is currently for discussion purposes only; the existing CPG is still in use.

Further concerns were raised by David Janes regarding the role of the MAG in setting the standards versus the day to day operations of the EMS. The Chair emphasised that ultimately, all MAG decisions have to be based on improving patient care. The Director advised that PHECC needs to sign off on best practice and that it is of great significance that the relevant people can now contribute to the ACS debate. Macartan Hughes felt that the role of the MAG was in the development the CPG's and that operational matters should be dealt with by the Clinical Care Committee. After much discussion the Chair suggested that the group await feedback from the relevant parties before getting into the detail of the redrafted ACS CPG.

Niamh Collins recommended that the MAG formally ask the ACS Programme for clarification regarding the use of clopidogrel versus prasugrel.

The Director informed the group that the Department of Health & Children officially notified the office that the matter of subsuming PHECC into the Health & Social Care Professionals Council (HSCPC) will be kept under review and will be re-visited in three years time.

Gerry Bury raised a concern regarding the acquisition of 12 lead ECG units and Macartan Hughes indicated that the HSE have purchased 50 machines and are currently in negotiations regarding the delivery and implementation of them.

3. ILCOR

In the meeting papers each treatment recommendation of the 2010 ILCOR guidelines was detailed on a table with comparisons of the AHA and ERC guidelines, along with PHECC's recommendations for change, where applicable.

Brian Power explained that he sought approval of the broad principles of the recommendations and that the specific details would be dealt with at a later meeting when the relevant CPG's are redrafted for review.

The following recommendations were agreed:

Part 5 – Adult Basic Life Support

Reference	Recommendations
A BLS 1 Pulse Check, Breathing Assessment, Signs of Circulation	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>
A BLS 2	<p>Practitioners Change initial sequence to CAB De emphasise pulse checks for cardiac arrest recognition</p> <p>Responders Change initial sequence to CAB</p>
A BLS 3 Etiology of Cardiac Arrest	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 4 Check for Circulation During BLS	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 5 Method to Locate Hand Position	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 6 Chest Compression Rate	<p>Practitioners Reinforce minimum compression rate of a minimum of 100 per minute and a maximum of 120 per minute</p> <p>Responders Reinforce minimum compression rate of a minimum of 100 per minute and a maximum of 120 per minute</p>
A BLS 7 Chest Compression Depth	<p>Practitioners Reinforce compression depth of 5 cm</p> <p>Responders Reinforce compression depth of 5 cm</p>
A BLS 8 Chest Decompression (recoil)	<p>Practitioners No change</p> <p>Responders No change</p>

<p>A BLS 9 Firm Surface for Chest Compressions</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 10 Feedback for Chest Compression Quality</p>	<p>Practitioners Clinical leaders should monitor quality of CPR during cardiac arrest.</p> <p>Responders No change</p>
<p>A BLS 11 “Cough” CPR</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 12 Precordial Thump</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 13 Fist Pacing</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 14 Airway, Opening the Airway</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 15 Passive Ventilation</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 16 Foreign-Body Airway Obstruction</p>	<p>Practitioners No change</p> <p>Responders No change</p>
<p>A BLS 17 Tidal Volumes and Ventilation Rates</p>	<p>Practitioners Reinforce inspiration volume of 500 to 600 mL</p> <p>Responders Reinforce inspiration volume of 500 to 600 mL</p>
<p>A BLS 18 Effect of Interruptions on Delivery of chest Compressions</p>	<p>Practitioners Reinforce minimising interruptions of chest compressions during resuscitation. Moving a patient in cardiac arrest should be a planned and co-ordinated process.</p>

	<p>Responders Reinforce minimising interruptions of chest compressions during resuscitation</p>
A BLS 19 Use of Filtering Devices for Rhythm Analysis During CPR	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 20 Compression-Ventilation Ratio During CPR	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 21 Chest Compression–Only CPR	<p>Practitioners No change</p> <p>Responders Add text box to CPG advising to perform compression only CPR if unable or unwilling to ventilate</p>
A BLS 22 Cervical Spine Injury	<p>Practitioners No change</p> <p>Responders No change</p>
A BLS 23 Emergency Medical Services (EMS) Systems Dispatcher Recognition of Cardiac Arrest	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>
A BLS 24 Dispatcher Instruction in CPR	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers No change</p>
A BLS 25 Risks to Victim	<p>Practitioners No change</p> <p>Responders No change</p> <p>Call takers Improve the discriminating questioning of call takers to identify cardiac arrest recognition</p>

Resolution: That the MAG approve PHECC recommendations relating to Part 5 – Adult Basic Life Support.

Proposed: Peter O’ Connor
Carried without dissent

Seconded: Macartan Hughes

Part 6: Defibrillation

D1 CPR Before Defibrillation	Practitioners Apply defibrillator pads as soon as possible and analyse Responders No change
D2 Self-Adhesive Defibrillation Pads Compared With Paddles	Practitioners No change Responders No change
D3 Placement of Paddles/Pads	Practitioners No change Responders No change
D4 Size of Paddles/Pads	Practitioners No change Responders No change
D5 Composition of Conductive Material	Practitioners No change Responders No change
D6 Biphasic Compared With Monophasic Defibrillation Waveform	Practitioners No change Responders No change
D7 Multiphasic Compared With Biphasic Defibrillation Waveform	Practitioners No change Responders No change
D8 Waveforms, Energy Levels, and Myocardial Damage	Practitioners No change Responders No change
D9 One-Shock Compared With 3-Stacked Shock Protocols	Practitioners No change Responders No change
D10 Fixed Versus Escalating Defibrillation Energy Protocol	Practitioners No change Responders No change
D11 Shock Using Manual Versus Semi-Automatic Mode	Practitioners Consider changing to manual mode for Paramedics to improve ‘hands off’ time for 2 nd and subsequent shocks. Responders No change
D11 Cardioversion Strategy in Atrial Fibrillation	Practitioners No change Responders No change
D12 Pacing (eg, Transcutaneous [TC], Transvenous [TV], Needle, and Fist)	Practitioners No change Responders No change
D13 Implantable Cardioverter	Practitioners No change

Defibrillator (ICD) or Pacemaker	Responders No change
D14 Predicting Success of Defibrillation and Outcome (VF Waveform Analysis)	Practitioners No change Responders No change
D15 Defibrillation in the Immediate Vicinity of Supplementary Oxygen	Practitioners No change Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 6 – Defibrillation.

Proposed: Lawrence Kenna
Carried without dissent

Seconded: Niamh Collins

Part7: CPR Techniques and Devices

T&D 1 Interposed Abdominal Compression (IAC)-CPR	Practitioners No change Responders No change
T&D 2 Active Compression-Decompression (ACD)-CPR	Practitioners No change Responders No change
T&D 3 Open-Chest CPR	Practitioners No change Responders No change
T&D 4 Load Distributing Band (LDB)–CPR	Practitioners No change Responders No change
T&D 5 Mechanical (Piston) CPR	Practitioners No change Responders No change
T&D 6 Lund University Cardiac Arrest	Practitioners No change Responders No change
T&D 7 Impedance Threshold Device (ITD)	Practitioners No change Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 7 – CPR Techniques and Devices.

Proposed: Declan Lonergan
Carried without dissent

Seconded: David Janes

Part 8: Advanced Life Support

ALS 1 Oropharyngeal and Nasopharyngeal Airways	Practitioners No change Responders No change
ALS 2 Cricoid Pressure	Practitioners No change Responders No change
ALS 3 Timing of Advanced Airway Placement	Practitioners No change Responders No change
ALS 4 Advanced Airway Versus Ventilation With Bag-Mask	Practitioners Introduce uncuffed supraglottic airway for EMT level Responders Introduce uncuffed supraglottic airway for CFR advanced level
ALS 5 Tracheal Intubation Versus the Combitube/Laryngeal Mask Airway	Practitioners No change Responders No change
ALS 6 Exhaled Carbon Dioxide Detection and Esophageal Detection Devices	Practitioners Introduce waveform capnography for Advanced Paramedic level Responders No change
ALS 7 Thoracic Impedance	Practitioners No change Responders No change
ALS 8 Supplemental Oxygen: 100% vs Titration	Practitioners No change Responders No change
ALS 9 Passive Oxygen vs Positive Pressure Oxygen During CPR	Practitioners No change Responders No change
ALS 10 Monitoring Ventilatory Parameters During CPR	Practitioners No change Responders No change
ALS 11 Monitoring Physiological Parameters During CPR	Practitioners Introduce waveform capnography for Advanced Paramedic level Responders No change
ALS 12 Automatic Ventilators vs Manual Ventilation During CPR	Practitioners No change Responders No change
ALS 13 Timing of Drug Delivery	Practitioners Administer Epinephrine after 1 st shock and before 4 th shock for VF/VT Responders No change
ALS 14 Vasopressors	Practitioners No change Responders No change
ALS 15 Atropine	Practitioners Removed Atropine for asystolic and PEA arrests Responders No change
ALS 16 Lidocaine, Procainamide,	Practitioners No change

Amiodarone, Bretylium, Magnesium	Responders No change
ALS 17 Calcium	Practitioners No change Responders No change
ALS 18 Steroid and Hormonal Therapy	Practitioners No change Responders No change
ALS 19 Buffers	Practitioners Consider Sodium bicarbonate for APs if tricyclic antidepressant overdose is the cause of the arrest. Administer 50 mmol bolus Responders No change
ALS 20 Fibrinolytics	Practitioners No change Responders No change
ALS 21 Chilled Fluid vs Room-Temperature Fluid	Practitioners Consider fluid challenge by APs for asystolic & PEA arrests Responders No change
ALS 22 Extracorporeal Circulatory Support During Cardiac Arrest	Practitioners No change Responders No change
ALS 23 Narrow-Complex Tachycardia (Excluding Atrial Fibrillation)	Practitioners Introduce vagal manoeuvres for APs Responders No change
ALS 24 Atrial Fibrillation	Practitioners No change Responders No change
ALS 25 Monomorphic VT	Practitioners Introduce Amiodarone for VT for APs Responders No change
ALS 26 Undifferentiated Regular Stable Wide-Complex Tachycardia	Practitioners No change Responders No change
ALS 27 Polymorphic Wide-Complex Tachycardia	Practitioners No change Responders No change
ALS 28 Bradycardia	Practitioners No change Responders No change
ALS 29 Cardiac Arrest Caused by Avalanche	Practitioners No change Responders No change
ALS 30 Pregnancy	Practitioners Reinforce left lateral tilt. Responders Reinforce left lateral tilt.
ALS 31 Cardiac Arrest in Morbid Obesity	Practitioners No change Responders No change
ALS 32 Cardiac Arrest Caused by Asthma	Practitioners No change

	Responders No change
ALS 33 Cardiac Arrest Caused by Anaphylaxis	Practitioners No change Responders No change
ALS 34 Cardiac Arrest Caused by Local Anesthetic	Practitioners No change Responders No change
ALS 35 Benzodiazepine Toxicity	Practitioners No change Responders No change
ALS 36 β-Blocker Toxicity	Practitioners No change Responders No change
ALS 37 Calcium Channel Blocker Toxicity	Practitioners No change Responders No change
ALS 38 Carbon Monoxide Toxicity	Practitioners No change Responders No change
ALS 39 Cocaine Toxicity	Practitioners No change Responders No change
ALS 40 Cyanide Toxicity	Practitioners No change Responders No change
ALS 41 Tricyclic Antidepressant Toxicity	Practitioners Introduce sodium bicarbonate for cardiac arrest caused by tricyclic antidepressant overdose for APs. Administer 50 mmol bolus Responders No change
ALS 42 Digoxin Toxicity	Practitioners No change Responders No change
ALS 43 Opioid Toxicity	Practitioners No change Responders No change
ALS 44 Cardiac Arrest During Coronary Catheterization	Practitioners No change Responders No change
ALS 45 Cardiac Arrest After Open or Closed Heart Surgery	Practitioners No change Responders No change
ALS 46 Cardiac Arrest Caused by Cardiac Tamponade	Practitioners No change Responders No change
ALS 47 Cardiac Arrest Caused by Pulmonary Embolus	Practitioners No change Responders No change
ALS 48 Cardiac Arrest Caused by Electrolyte Disorders	Practitioners No change Responders No change
ALS 49 Ultrasound During Cardiac Arrest	Practitioners No change

	Responders No change
ALS 50 Postresuscitation Treatment Protocol	Practitioners ROSC patients with APs in attendance should be transported to hospitals that have appropriate facilities to manage ROSC. Responders No change
ALS 51 Pulmonary Embolism	Practitioners No change Responders No change
ALS 52 Ventilation	Practitioners No change Responders No change
ALS 52 Controlled Oxygenation	Practitioners Titrate O ₂ to 94 – 98% following ROSC for Paramedics and Advanced Paramedics Responders No change
ALS 53 Fluid Therapy	Practitioners Consider fluid challenge if the patient is hypotensive following ROSC for APs Responders No change
ALS 54 Hemodynamic Optimization	Practitioners Consider fluid challenge if the patient is hypotensive following ROSC for APs Responders No change
ALS 55 Cardioactive Drugs	Practitioners No change Responders No change
ALS 56 Antiarrhythmic Drugs	Practitioners No change Responders No change
ALS 57 Mechanical Circulatory Support	Practitioners No change Responders No change
ALS 58 Prevention and Treatment of Hyperthermia	Practitioners Consider active cooling Responders Consider active cooling.
ALS 59 Therapeutic Hypothermia	Practitioners Active cooling following ROSC, at U on AVPU scale, regardless of arrest rhythm. Responders Consider active cooling.
ALS 60 Seizure Control	Practitioners No change Responders No change
ALS 61 Blood Glucose Control	Practitioners EMTs to check blood glucose following ROSC Responders No change
ALS 62 Steroid Therapy	Practitioners No change Responders No change
ALS 63 Hemofiltration	Practitioners No change

	Responders No change
ALS 64 Neuroprotective Therapy	Practitioners No change
	Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 8 – Advanced Life Support.

Proposed: Valerie Small
Carried without dissent

Seconded: Peter O’ Connor

8. A.O.B.

Frank O’ Malley enquired whether there was any further training planned for paramedics to increase their scope of practice. The Chair indicated that he would be interested in getting specific feedback and asked that Frank O’ Malley bring further details to the next meeting for consideration.

The Chair thanked the group for their attendance and Brian Power wished members a happy Christmas.

The next MAG meeting will be held in the PHECC office Naas, date to be advised.

Signed: _____

Date: _____



The Medical Advisory Group

Minutes 2nd and 3rd November 2010

The Sheraton Hotel Athlone

In Attendance

Cathal O'Donnell (Chair)
Stephen Cusack
John O'Donnell
David Menzies
Mark Doyle
Peter O'Connor
Niamh Collins
Sean Walsh
Valerie Small
Lawrence Kenna
Zelie Gaffney (2nd only)
Gerry Bury (3rd only)
Declan Lonergan (3rd only)
Mac Hughes
Paul Lambert
Martin O'Reilly

Present

Geoff King (Director)
Pauline Dempsey
Brian Power
Deirdre Borland
Peter MacFarlane
Mark Whitbread
Kieran Daly
Annamay Tiernan

Apologies

David Janes
Brendan Whelan
Fergal Hickey

1. Chair's Business

The Chair and MAG members asked that their condolences be passed onto David Janes on the death of his father.

The Chair welcomed David Menzies, interim course director of the UCD AP programme to the MAG. The Chair also congratulated the PHECC office on receiving a commendation at the Irish Healthcare Awards in the category of Best Public Health Initiative for the citizen CPR campaign.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 23rd September 2010 be approved.

Proposed: Niamh Collins
Carried without dissent

Seconded: Mark Doyle

3. Education and Training Standards

Pauline Dempsey introduced the Draft 2011 Education and Training Standards and asked the Group for their feedback on each.

- CFR
 - Niamh Collins suggested the inclusion of basic wound care. The Director indicated that this is catered for within other levels.
 - Lawrence Kenna suggested that for the airway module uncuffed supraglottic devices be specified and indicated for adult use only.
 - Macartan Hughes suggested that certain skills be limited to approved organisations. The Director indicated that quality of teaching of skills are assured since training and recertification is undertaken by recognised institutions.

- Emergency Care
 - Martin O'Reilly commended the core Emergency Care course. He expressed a concern however that the EC Firefighter may be viewed as a downgraded syllabus compared to the EFR course which is undertaken currently by most retained fire services. The Director stressed that this course was not intended for full time fire services; rather an option for people working within an industry where fire is a hazard.

- EFR – Fire
 - Pauline Dempsey gave an overview of the work undertaken by CPR in UL of the EFR Fire course. Martin O'Reilly asked the obstetrics/childbirth be retained as part of the course. Zelig Gaffney agreed that retaining the obstetrics module is useful to demystify childbirth and aid calm approach to the care of patients particularly the care of the newborn. The Director advised that obstetrics/childbirth will be retained in the EFR Standard but may be a watershed issue for Fire Services in relation to embracing EFR-Fire. The issue will be looked into further.

- EMT
 - Pauline Dempsey informed the group that feedback received thus far included a request for the authorisation for the administration of Salbutamol and Epinephrine without being prescribed. The group agreed that Salbutamol could be authorised without prescription but Epinephrine should remain with the requirement for prescription.

- Paramedic
 - Lawrence Kenna asked that a module specific to elderly patients be included. Niamh Collins asked that identifying at risk groups such as abuse of the elderly be included.

- Advanced paramedic
 - Niamh Collins asked that the group consider specifying add on unit of competencies to cater for organisational or geographic requirements. The Chair indicated that this would pose difficulties due to the nature of AP working across both rural and urban areas. The Director indicated that it will be given consideration.

4. ILCOR

Brian Power tabled the section on BLS treatment recommendations of the 2010 ILCOR guidelines. This consisted of a table with comparisons of the AHA and ERC guidelines. It identified appropriate CPGs and made recommendations for changes where applicable. The group felt that more time was required to review the document. A decision was made that if anyone had feedback he/she would e-mail Brian Power within two weeks. Brian to present feedback at next meeting. The meeting was happy with the table layout and Brian undertook to present each section of the 2010 guidelines in the same format.

5. MAG Membership

The Chair informed the group that it was timely to review the membership and consider possible improvements to the effectiveness of the MAG. Stephen Cusack welcomed this process and questioned the rationale of UCD having an automatic seat on the MAG; he asked that consideration be given to including further training institutions in the membership structure.

Zelie Gaffney suggested that having a representative of the ICGP would be a useful step in widening GP's understandings of the scope of Pre-Hospital Practitioners.

A discussion was held regarding the feasibility of including a wider range of practitioner levels to the membership. The group concurred that membership should be altered to include a practicing Paramedic and Emergency Medical Technician.

The group suggested that themed meetings be hosted on a rotating basis so that voluntary and auxiliary organisations, private operators and responders groups could be involved in the MAG's work. It was also suggested that as the clinical need arose specialist clinicians such as Cardiologists, Obstetricians and Anaesthetists/Intensivists etc be invited as contributors to MAG.

The non attendance of MAG members was discussed at length. It was acknowledged that while current staffing circumstances may provide obstacles to member's availability, the chair asked that an effort be made by all members to attend meetings as regular attendees were left with an unfair proportion of the workload of MAG. It was agreed that the Chair would review the attendance from the last two years and write to members who have not attended at least two meetings per annum to ask for more active involvement. The Chair indicated that meetings were held in various locations to facilitate members and those reasonable steps will continue to be taken to insure each member has ample opportunity to contribute to MAG.

Deirdre Borland reminded the group that meeting papers are available to members a week in advance of the meeting there was a facility to contribute comments and suggestions in advance via email.

It was agreed that 3 positions on MAG would be filled “at the Chairs invitation” to ensure that valuable contributors would not be ineligible to continue on MAG due to change in employer etc.

On the suggestion of Stephen Cusack it was agreed to invite a representative from the Army Medical Corps of the defence forces to take up a position on MAG.

6. A presentation session was conducted in the afternoon. The following speakers participated and were asked to contribute to agenda item 7 at the resumption of the meeting.

- Anna May Tiernan – Irish Society for Immediate Care Advanced Paramedic Forum
- Prof. Peter McFarlane - Professor of Electrophysiology University of Glasgow
- Mark Whitbread - London Ambulance Service Clinical Practice Manager
- Dr Kieran Daly - Consultant Cardiologist at University College Hospital Galway

7. ACS changes & 12 lead ECG interpretation

a) – PPCI v thrombolysis

A lengthy discussion was held regarding the clinical evidence and cost benefit regarding APs training and delivering thrombolytic agents in the pre-hospital setting. Key items discussed included:

- Prof Kieran Daly’s direction that the ACS programme will be advising the expansion of Primary PCI facilities and his research indicating that the best outcome for patients are achieved by accessing PPCI facilities directly rather than in field or non PCI centre thrombolysis regardless of timeframe expect in a very small subject group (young male, < 65 years, with large MI who can receive thrombolytic agent within 2 hours of onset of symptoms).
- Niamh Collins outlines the large costs involved in training APs and the cost of carrying stock of the drug (€1200) may be spent better in areas such as ECG interpretation as it would benefit the majority of patients who Practitioners treat.
- The Director indicated that he felt there was a risk in continuing Thrombolysis as a treatment option for APs when the opportunity to practice the skill and therefore retain the skill was so limited.
- Mark Doyle and Lawrence Kenna cautioned against immediately revoking the practice of AP thrombolysis until defined PPCI systems were in place and communication with the effected hospitals were engaged with.
- Mark Whitbread agreed with this, stressing the importance of direct 24hr Cath Lab access and cooperation between the ambulance service and receiving hospital to insure swift “door to balloon” time. He also indicated that practitioner fluency in ECG interpretation was key to decision making in this area, although automated interpretation serves as a useful second opinion it does not replace Practitioner knowledge.

- If the patient is transported to the ED in a hospital with a PPCI facility the patient should not be removed from the ambulance trolley while being assessed as it delays transfer to the Cath lab. The ambulance Practitioners should remain and transfer the patient on their trolley as soon as practical.
- The Director indicated that there may be scope for allowing certain geographic areas continue with the practice if they deem it necessary.
- It was suggested that the Chair and Director will draft a letter outlining MAG's position to the HSE, Ambulance Service and Dr Kieran Daly. The group will be circulated a draft in advance of sending.

b) – Update of ACS CPG

In light of the previous discussions and presentations the following changes were suggested in relation to the ACS CPG

- Niamh Collins suggested using the definition of a MI and criteria as per the AHA Guidelines 2010 (Nov 2nd). She also cautioned that many patients arrive at hospitals themselves and not via the ambulance service. She expressed a concern that in Cork and Kerry there are currently only 5 devices capable of conducting 12 lead ECGs. Macartan Hughes insured that new devices have been ordered and that this would be resolved within the coming weeks
- The dosage of Clopidogrel be increased to '600 mg following the identification of STEMI' and should be contraindicated if the patient is on daily Clopidogrel.
- Change to 'symptoms 20 mins – 2 hours'
- The Algorithm to follow the steps of STEMI – yes – PPCI within 120 mins

The group acknowledged that and changes to the ACS CPG would have a practical impact on hospitals and it was therefore appropriate to send the new CPG along with the letter on the MAG's position on ACS PPCI/thrombolysis.

It was agreed that the starting point for the EMT CPG for ACS be changed from 'Cardiac chest pain' to 'Suspected ACS'. 'Suspected' be also included in the AP/P CPG starting point.

Resolution: That the Medical Advisory Group draft a position letter on ACS PPCI/thrombolysis and a revised ACS CPG and communicate it to the affected parties.

Proposed: Valerie Small
Carried without dissent

Seconded: Stephen Cusack

8. AP upskilling part 2

c) – Thrombolysis

This item was covered in the previous agenda item so was not discussed further.

d) – Paediatric Advanced Airway

Gerry Bury asked the group to consider the necessity for APs to be trained in paediatric intubation, as it was a difficult to get access to opportunities for students to practice the skill in training. It is also used in very limited conditions ie. paediatric cardiac arrest. Sean Walsh informed the group that the skill is of little difference than intubation an adult except in those under 1 year.

Lawrence Kenna suggested the use of a supraglottic device may be a good compromise. Macartan Hughes agreed as ventilation using a BVM in a moving ambulance posed a serious health and safety risk to practitioners.

Niamh Collins indicated that laryngoscopy was still a useful skill for AP's to have.

Sean Walsh committed to consult with his colleagues and report back to MAG at the next meeting.

Gerry Bury undertook to assess the training costs and implications of laryngoscopy and intubation.

e) – Female Catheterisation for prolapsed cord/post-partum haemorrhage.

Gerry Bury informed the group that the AP programme was facing major challenges in securing opportunities for APs to gain experience in the skill of female catheterisation. Stephen Cusack questioned the need to train in a skill that was required in such rare occurrences. The Director informed the group that although rare, it is a relatively simple skill that has life saving benefits to the baby. Paul Lambert agreed and suggested that mannequin training was a suitable means for learning this skill. Valerie Small informed the group that nurses learn the skill of male and female catheterisation on mannequins in the classroom setting and by supervised hospital practice.

Mark Doyle suggested that a risk matrix be devised to examine the value of training APs in high risk/low frequency/high benefit skills.

f) – Mental Health Emergencies

Gerry Bury questioned the appropriateness of the Mental Health Emergency CPG, indicating he felt it was contra to the Mental Health Act 2005. Stephen Cusack agreed that the forced administration of a sedative was not the most undesirable outcome in an instance of a mental health emergency. He asked if the use of restraints could be a viable option while awaiting the Gardaí or Mental Health Services.

Mark Doyle suggested that the route of a practitioner applying for an involuntary admission be investigated.

The Director committed to seek legal advice in the issue.

9. Prevention of Transmission of Blood Borne Diseases

A HSE Circular re the prevention of blood borne diseases was included in the meeting papers for the group's information. As currently no CPG advocates the use of exposure prone procedures, the circular currently did not impact on any of MAGs recommendations.

Gerry Bury indicated that a number of Practitioners have carried out interesting studies regarding infection control issues such as handwashing and uniform contamination and he would seek permission to include the studies in the next meeting papers.

10. Medications

– Morphine – max dose, Oramorph – dose & repeat timings

Brian Power informed the group that the current dosage for Morphine PO (Oramorph) is low when compared to the dosages listed in the paediatric BNF and other international examples. Sean Walsh agreed, however for safety he suggested that the lower age limit should be 1 year (up to 14 years). He recommended a dose of 0.3 mg/Kg to a max of 15 mg.

Brian Power also asked the group to consider increasing the maximum dose of Morphine IV for patients with musculoskeletal injuries, following practitioner feedback.

Niamh Collins suggested that age and body weight as well as impaired renal functions be considered in the administration of morphine. Brian Power indicated that this was covered in the contra indications section of the CPG.

John O'Donnell also advised caution in cases where patient entrapment and inadequate splinting may result in higher doses of Morphine. However when the patient is extricated and appropriately splinted the requirement for pain relief is reduced thus the Morphine dose may be excessive.

The Chair indicated that if a dosage has not had a therapeutic effect the likelihood of a further dose having a toxic effect is very low.

Resolution: That the Medical Advisory Group amends the paediatric dose of Morphine PO (Oramorph) to a one off dose of 0.3 mg/Kg with a max dose of 15mg for 1 to < 14 years, where < 1 year is contraindicated. The Medical Advisory Group also amends the maximum dose of Morphine IV to 16 mg for musculoskeletal pain.

Proposed: Peter O'Connor

Seconded: Macartan Hughes

Carried without dissent

– Paracetamol & Ibuprofen – guidance for rounding of volume (mL) administered.

Resolution: That the Medical Advisory Group allow for the rounding off of volume administered of Paracetamol and Ibuprofen to one decimal place in mL.

Proposed: Peter O'Connor

Seconded: Niamh Collins

Sean Walsh suggested that the paediatric dose of Ibuprofen be increased from 5 mg/Kg to 10 mg/Kg. He also suggested that the current practice of Paracetamol and Ibuprofen being contraindicated if administered within the previous 6 and 8 hours respectively be reviewed. Sean outlined his practice

where the dose is adjusted downward by the amount given by parents etc. within the respective timeframes. He further recommended that the time frame for Ibuprofen be reduced to 6 hours.

Resolution: That the Medical Advisory Group increase the paediatric dose of Ibuprofen to 10 mg/Kg and that Ibuprofen may be administered if given within the previous 6 hours, provided the dose is adjusted downwards of by the amount given. Also that Paracetamol may be administered if given within the previous 4 hours, provided the dose is also adjusted downwards of by the amount given.

Proposed: Sean Walsh
Carried without dissent

Seconded: John O'Donnell

11. Priority Dispatch Standard

Brian Power gave an overview to the group of the MAG AMPDS sub group recommendations for the appropriate response levels using the dispatch cross reference (DCR) code within the EMS priority dispatch standard. The meeting papers described how the dispatch codes may differ from the DCR codes due to being modified to suit Ireland. The Chair outlined the tedious nature of the task and congratulated those involved for the work undertaken in completing this task.

Resolution: That the Medical Advisory Group approve the dispatch codes process as outlined in the meeting papers for the EMS Priority Dispatch Standard.

Proposed: Gerry Bury
Carried without dissent

Seconded: Peter O'Connor

12. A.O.B.

The Director relayed the compliments of the invited guests regarding the MAG process to the members.

Sean Walsh asked that the group consider the inclusion of nebulised adrenaline for paediatric stridor. It was agreed to discuss this further at a future meeting.

The Chair asked that the group discuss the issues that face practitioners when confronted with a medical doctor who instructs them to treat a patient in a manner contra to those outlined in the CPGs. The group agreed that this was a serious issue that merited further discussion at the next meeting.

The Chair thanked the group for their attendance over the two days and expressed his gratitude to the speakers for making the meeting so productive.

The next MAG meeting will be held in the PHECC office Naas on Thursday 16th December at 10:30am.

Signed: _____

Date: _____

Medical Advisory Group

Draft Meeting Minutes 23rd September 2010

10.30am PHECC Office Naas

Present:

Cathal O' Donnell (Chair)
Niamh Collins
Mark Doyle
George Little
Paul Lambert
David Janes
Declan Lonergan
Sean Walsh

Apologies:

Conor Egleston
Zelie Gaffney
Valerie Small
John O'Donnell
Martin O'Reilly
Frank O'Malley
Lawrence Kenna
Macartan Hughes
Brendan Whelan
Michael Garry
Stephen Cusack
Richard Lynch

In Attendance:

Geoff King (Director)
Brian Power
Jacqueline Egan
Martin Flaherty
Deirdre Borland

1. Chairs Business

The Chair greeted the assembled members to the September MAG meeting. The Chair welcomed new MAG member George Little, newly appointed Medical Advisor to the HSE Eastern Division. He also welcomed Martin Flaherty, Deputy Chief Executive, London Ambulance Service, who is currently on secondment to the HSE as Ambulance Advisor.

2. Minutes and Matters Arising

Cathal O'Donnell flagged an issue of patient clinical safety regarding transfer timeframe of non emergency patients from hospitals without specific services, i.e. surgery. In light of the implementation of AMPDS, he outlined a case where a patient requiring surgery was left waiting transfer for over 10 hours, as GP calls received priority, although may not be a clinical priority. The patient subsequently missed his theatre slot and had to wait until the next day for surgery.

David Janes asked for an update regarding the PHECC position paper. The Director informed the group that PHECC's budget and staff will no longer be scheduled to be incorporated into the HSCPC. He also informed the group that the Department of Health and Children has agreed to meet with PHECC in the coming months and an acknowledgement has been made regarding the importance of PHECC's roles and functions.

Resolution: That the minutes from the Medical Advisory Group meeting of 8th June 2010 be approved.

Proposed: Niamh Collins

Seconded: Declan Lonergan

Carried without dissent

3. Amiodarone - limited availability of minijets

The limited availability of Amiodarone minijets and the difficulties regarding correctly drawing up the drug while in a pre-hospital environment were discussed. Niamh Collins informed the group that she had sought clarification from manufacturers Sanfo-Aventis regarding the use of undiluted Amiodarone in cases of cardiac arrest. While the manufactures guidelines specify dilution with 5% dextrose, a number of clinical papers have questioned the need for dilution.

Resolution: The Medical Advisory Group recommends that in the absence of minijet format the process for Amiodarone administration remains as agreed at the last meeting i.e;

Adults:

VF/VT arrest 1st dose:- 2 X (150 mg in 3 mL) ampoules followed by 10 mL NaCl flush.

2nd dose:- 1 x (150 mg in 3 mL) ampoule followed by a 10 mL NaCl flush.

ROSC 2 X (150 mg in 3 mL) ampoules in 500 mL Dextrose 5% and infused at 1 mg per minute.

Paediatrics:

VF/VT arrest Appropriate volume at 5 mg/Kg of (150 mg in 3 mL) ampoule concentration followed by a 10 mL NaCl flush.

Proposed: David Janes

Seconded: Mark Doyle

Carried without dissent

4. ACS changes

The Director informed the group that the Acute Coronary Syndrome Group is likely to recommend the transport for all cases of STEMI for PCI if within 90 minutes of an appointed facility. PHECC ACS CPG will need to be updated in light of this as it currently directs the practitioner to Thrombolysise if symptoms are less than 3 hours and a transport time of over 2 hours is envisaged.

A discussion ensued regarding the correct identification and definition of STEMI and the diagnostic equipment available to practitioner. Martin Flaherty commented that few UK services rely on telemetry due to cost and technological challenges. He added that UK services were increasingly moving away from thrombolysis in favour of PCI.

David Janes stated that appropriately trained ambulance Practitioners can effectively identify STEMIs. The Chair agreed that the current training process encourages practitioners to make autonomous decisions and engage in communication with Emergency Department Staff.

The Director informed the group that the Acute Coronary Syndrome Group are of the opinion the 3 PCI centres should be developed nationally; Dublin, Cork and Galway. Mark Doyle expressed serious concerns that a large proportion of the population would be left at risk if PCI services were limited to such a limited base. George Little suggested that 24hr PCI services would likely be shared between several bases within a region, resulting in a wider geographic area being covered.

It was suggested that a session be devoted to this area at the next MAG meeting, it was suggested that the following guests be invited to present at the meeting in relation to ACS:

- A Representative from the ISIC AP Forum
- Dr Kieran Daly - Consultant Cardiologist at University College Hospital Galway
- Prof. Peter McFarlane - Professor of Electrophysiology University of Glasgow
- Mark Whitbread - London Ambulance Service Clinical Practice Manager

4.1 Administration of Efiect® (Prasugrel)

Brian Power informed the group of new research papers indicating that a new drug to the market, Prasugrel may be more effective than Clopidogrel which is currently listed on the Medication Formulary and PHECC CPGs. He suggested in light of the amount of time it takes to get Ministerial sign off for a new drug, that the process should be commenced of including this in the medication products schedule 7.

Niamh Collins questioned the value of Prasugrel over Clopidogrel, given the limited indications for its use and issues regarding increased bleeding, she would be hesitant to use it over Clopidogrel.

Brian Power clarified that should a drug be included in the medication products schedule 7, it cannot be administered by Practitioners unless included in a CPG.

It was agreed that steps should be taken to include it in the medication products schedule 7.

Brian Power also requested that if MAG members identified a medication with a potential pre-hospital application, MAG should be notified to enable its inclusion onto the medication products schedule.

5. Education and Training standards 2011

The Director invited the group to provide feedback on the draft Training and Education Standards 2011 which were circulated to the members prior to the meeting. He also gave an outline of the Draft PHECC Responder Course Awards Structure 2011 which was included in the meeting papers.

David Jane's questioned the appropriateness of teaching high level skills to responder's who may not have the opportunity to practice skills on a frequent basis. The Director suggested that

currently EFR were learning skills such as BVM which in his opinion were of greater difficulty to those listed in the draft structure.

The Director asked that all feedback be sent to Pauline Dempsey Programme Development Officer.

6. MAG membership

The Chair informed the group that MAG is currently half way through its 4 year term, and a review of the current membership was timely. The Director explained that a request has been made by the AP forum for representation on MAG, as well as a request that an operational paramedic be appointed. He added that currently 5 APs were part of the group but the inclusion of a Paramedic may be valuable. A request for voluntary organisations to be represented on Council was also received. The Director suggested that the Clinical Care Committee may prove a better forum for voluntary groups. David Janes advised that many decisions taken at MAG have an implication for voluntary organisations. Brian Power suggested that a minimum clinical level could be specified for those attending MAG.

It was agreed that this issue be discussed further at the next meeting.

A representative of the ISIC AP Forum is to be invited to the next MAG to give a presentation of their work thus far.

7. Information management

Jacqueline Egan gave an overview of the PHECC Pre-Hospital Information Standard which was included in the meeting papers. Also included was the draft 3rd Edition Patient Care Report (PCR) which has been developed following feedback from Practitioners and with input from the OCHAR group and HIQA. On Sean Walsh's request, Jacqueline Egan gave an overview on the purpose and use of the PCR.

Mark Doyle suggested that the text block in the Refusal of Treatment and or Transport section be removed as it is a repeat of what is contained in the CPG. Niamh Collins stressed the importance of training in the area of refusal of treatment/transport.

The Chair congratulated Jacqueline Egan on the work put into the Information Standard and on the much improved PCR.

8. Draft PHECC Field Guide

The Chair informed the group that in light of the prevalence of unofficial off the shelf field guides currently in use by Practitioners; concerns have arisen regarding potentially incorrect information contained therein. As a result PHECC has developed a Practitioner Field guide. A draft version of this guide was circulated in the meeting papers. Frank O'Malley (in absentia) asked that his support for the field guide be noted, as it would prove an excellent aid for practitioners.

The Chair congratulated Brian Power on the development of the Field Guide.

The Director requested that the draft field guide be circulated to all MAG members and their comments sought.

9. AP upskilling part 2

Niamh Collins informed the group that certain elements of the AP upskilling programme were proving problematic for UCD in particular:

- Female Catherisation/Post Partum Hemorrhage/ Prolapsed Cord – cutting umbilical cord if it is wrapped around neck.
- Paediatric Airway Management
- Management of mentally ill patients who refuse transport or treatment

The Chair expressed a concern that UCD would not deliver the upskilling in accordance with Council standards and as per the CPG as approved by MAG where UCD representatives had an opportunity to raise any issues prior to their approval.

Niamh Collins informed the Chair that while she cannot now speak for UCD, in her previous role as Course Director of the UCD AP programme she did inform the Director of their concerns.

The Director indicated that MAG was the correct forum to raise any concerns. He also suggested that all 4 items raised be discussed in depth at the next MAG meeting.

10. Prevention of Transmission of Blood Borne Diseases

It was agreed to defer this item to the next MAG meeting.

11. Citizen CPR campaign

A synopsis of the Citizen CPR campaign was presented in the meeting papers.

12. Priority Dispatch Standard

Brian Power informed the group that a meeting would be held that afternoon of the EMS priority dispatch standard subgroup to insure accurate interpretation of the new DCR table.

Cathal O'Donnell requested that the urgent inter hospital transfers be addressed by the subgroup.

Resolution: That MAG accepts in principle the deliberations of the EMS priority dispatch standard subgroup to affect changes to the DCR table and inter-hospital urgent transfer protocol for recommendation to Council.

Proposed: David Janes
Carried without dissent

Seconded: Paul Lambert

13. AOB

Declan Lonergan asked that the group give guidance regarding the repeat dosage time in regard to Oramorph and also guidance regarding the rounding up or down of Paracetamol or Ibuprofen volume (mL) administered.

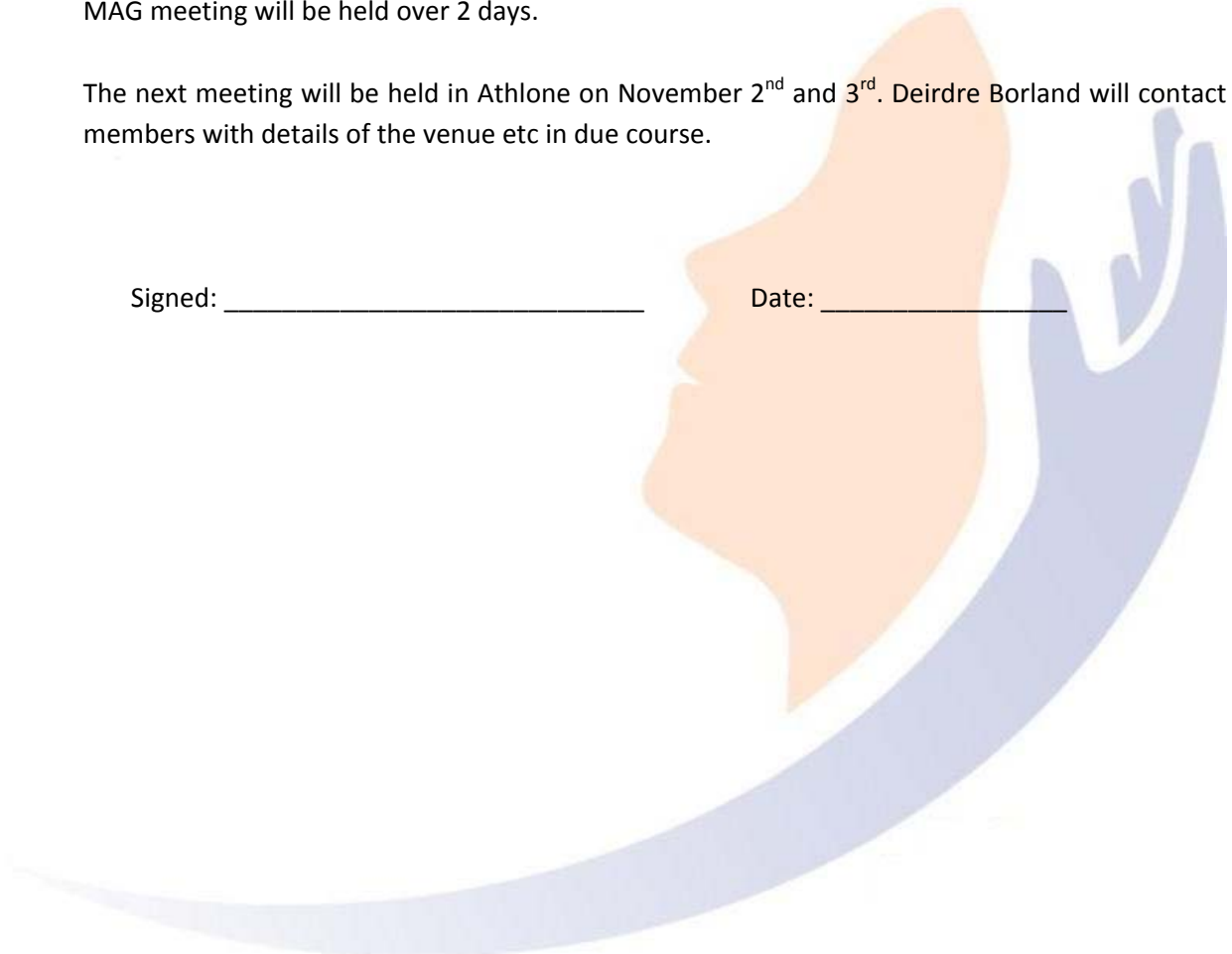
The Chair agreed that this would be addressed at the next meeting.

Due to the large volume of items deferred from today's meeting, it was agreed to hold the next MAG meeting will be held over 2 days.

The next meeting will be held in Athlone on November 2nd and 3rd. Deirdre Borland will contact members with details of the venue etc in due course.

Signed: _____

Date: _____



Medical Advisory Group

Meeting Minutes 8th June 2010

Present:

Cathal O' Donnell (Chair)
Niamh Collins
Martin O'Reilly
Lawrence Kenna
Frank O'Malley
Paul Lambert
Macartan Hughes
Declan Lonergan

Apologies:

Mark Doyle
Zelie Gaffney
Valerie Small
John O'Donnell
Fergal Hickey
Sean Walsh
Peter O' Connor
Conor Egleston
Brendan Whelan
Michael Garry

In Attendance:

Brian Power
Marion O'Malley

1. Chairs Business

The Chair welcomed the assembled members to the June MAG meeting. The Chair expressed his sympathies, on behalf of the group, on the tragic death of Simon Sexton, Paramedic, PIN 4600 who died while on duty.

2. Minutes and Matters Arising

Macartan Hughes indicated that the issue of 3rd Edition CPG implementation which was discussed in agenda item 7. (AOB) was still not rectified and it was agreed to take the item back to the group at its next meeting.

Resolution: That the minutes from the Medical Advisory Group meeting of 30th March 2010 be approved.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Niamh Collins

3. End of Life (DNR) CPG final draft

The final draft of the End of Life (DNR) CPGs were presented by Brian Power to the group for approval. After a brief discussion it was recommended that the CPGs have an information box inserted stating "Confirm and agree procedure with clinical staff in the event of a death in transit".

Resolution: That the group approve the 'End of Life - DNR' CPG at Advanced Paramedic & Paramedic level, subject to the change recommended above.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Frank O' Malley

Resolution: That the group approve the 'End of Life -DNR' CPG at Emergency Medical Technician level, subject to the change recommended above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Paul Lambert

Niamh Collins sought authorisation to use the End of Life - DNR CPG during AP upskilling which takes place on 21st and 22nd June 2010. The Chair approved her request, however, stipulated that the APs be made aware that the CPG was still in draft form until approved by the Council meeting of 24th June 2010.

**4. Amiodarone – limited availability of minijets
Lidocaine – limited availability also**

Brian Power informed the group that he has received numerous queries seeking advice on the recommended use of both Amiodarone and Lidocaine. Consequently, a draft recommendation was tabled for Amiodarone use in the absence of minijet format, for the approval of the group.

Cathall O'Donnell stated that Amiodarone was a superior medication to Lidocaine for refractory VF and had ILCOR endorsement. It could not be justified therefore to recommend the routine replacement of Amiodarone with Lidocaine. Lidocaine use was facilitated on the CPG due to the unavailability of Amiodarone at that time.

Niamh Collins indicated that the use of Amiodarone ampoules may introduce some safety risks during a cardiac arrest; however acknowledged that while Amiodarone is a better drug, there should be a better system for its delivery as it is currently not without risk.

Paul Lambert suggested that the calculation for paediatric dosage should be referenced to an age related chart for a recommended dosage but local policy will decide what to do.

Niamh Collins stated that for cost reasons one ED in Dublin routinely used Amiodarone ampoules instead of minijets.

The draft was amended as follows;

Delete the 3rd paragraph

Amend the suggested process paragraph to read:-

Adults: 1st dose, 2 X (150 mg in 3 mL) ampoules followed by 10 mL NaCl flush.
2nd dose, 1 x (150 mg in 3 mL) ampoule followed by a 10 mL NaCl flush.
ROSC 2 X (150 mg in 3 mL) ampoules in 500 mL Dextrose 5% and infused at 1 mg per minute.

Paediatrics: Appropriate volume at 5 mg/Kg of (150 mg in 3 mL) ampoule concentration followed by a 10 mL NaCl flush.

Resolution: That the group approve the recommendation for the process for the administration of Amiodarone in the absence of minijets as per above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Macartan Hughes

5. Prevention of Transmission of Blood Borne Diseases

Mark Doyle, at the March MAG meeting, asked that the circular relating to the prevention of transmission of blood borne diseases be included in the papers for discussion. In Mark's absence it was agreed to defer this agenda item.

6. Treat & Referral/Discharge policy

Brian Power presented a position paper to the group on a Treat & Referral/Discharge policy. He indicated that it is a broad principle for treat & referral, and, if adopted, would be the framework around which treat & referral CPGs would be developed. He detailing the New South Wales (NSW) Clinical Assessment and Referral (CARE) programme, which is in operation in NSW for three years. The CARE programme has been continuously audited since inception and to date there has been no adverse events associated with it. It has proved so successful that CARE is being implemented into the Paramedic training programme for all new Paramedics in NSW.

Brian Power requested that MAG adopt the principles of the CARE programme and subsequently decide which clinical conditions are appropriate for referral in the Irish setting.

Cathal O'Donnell requested that patient decision making capacity be an essential element of the process.

Niamh Collins recommended, as a default mechanism, that if a patient has a treat & referral clinical pathway that their GP be notified of same.

It was also suggested that if a patient requested transport to an emergency department, regardless of acuity level, that this would be respected and provided.

Brian Power pointed out that these were standard practices in the CARE programme.

Brian Power indicated that for capturing data a standardised approach is needed for clinical pathways and that there would be three possible outcomes if a patient meets the criteria for treat & referral:

1. Treat and immediate referral for follow up care with a health care practitioner
2. Treat and referral for follow up care within 24 hours
3. Treat and referral for self care with advice

Niamh Collins suggested the policy be piloted on APs initially and also indicated that communications with service providers, hospitals and GPs needs to be improved.

Resolution: That MAG adopt the principles of the NSW CARE programme. The CPGs, patient information leaflets and the health provider feedback forms be adopted to suit Irish healthcare conditions. The three clinical pathways as recommended above be utilised for treat & referral.

Proposed: Macartan Hughes

Seconded: Niamh Collins

Carried without dissent

7. Prospectus Report

Included in the papers for information was the Prospectus report. Brian Power indicated to the group that PHECC engaged Prospectus to produce a report designed to inform Council, Committees, the DoHC and other stakeholders of the ongoing implications for PHECC's functions.

He highlighted PHECC's concerns that all of functions would be preserved, given that under current legislation only 20% of PHECC's functions, those associated with registration, would be preserved if PHECC were subsumed directly into the Health and Social Care Professionals Council (HSCPC).

8. Citizen CPR – for information

Information on the launch of the public awareness campaign of the "Citizen CPR" was included in the papers. The official launch will take place on the 24th June in the Light

House Cinema, Smithfield, Dublin with media TV and cinema adverts and road shows going live on the 25th June 2010. Brian Power acknowledged Deirdre Borland's excellent work and commitment to the project. The Chair highlighted that it was a very positive and important project and that he hoped it would make a difference to cardiac arrest survival in Ireland.

9. AOB

9.1 Priority Dispatch Standard

The Medical Priority Dispatch System (MPDS) has launched version 12.1 of its software. As with the previous version a clinical sub group with MPDS expertise (HSE, DFB & PHECC) reviewed new DCR table content and made recommendations to MAG. Brian Power presented the findings to MAG for approval.

Protocol 27: Stab/gunshot/penetrating trauma;

add new suffix 'Y self-inflicted stab'

Resolution: That MAG approves the addition of the new suffix to Protocol 27 as detailed above.

Proposed: Macartan Hughes

Carried without dissent

Seconded: Declan Lonergan

Portocol 28: Stroke (CVA);

Change 28-C-3 from 'Speech problems' to 'Sudden speech problems'

Divide 28-C-4 into three new codes;

- 28-C-4 Sudden weakness or numbness (one side)
- 28-C-5 Sudden paralysis of facial droop (one side)
- 28-C-6 Sudden loss of balance or coordination

Change '28-C-5 Vision problems' to '28-C-7 Sudden vision problems'

28-C-6 becomes 28-C-8

28-C-7 becomes 28-C-9

28-C-8 becomes 28-C-10

28-B-1 becomes 28-C-11

A new stroke diagnostic tool has been added which results in 'Partial' (suffix C, D or E), 'Strong' (suffix F, H or I), 'Clear' (suffix J, K or M) or 'No' (suffix X, Y or Z) evidence of a stroke. The suffix relate to time frame less than 4 hours, greater than 4 hours or unknown time frame respectively.

Resolution: That MAG approves the ammendments and additions of the DCR table for Protocol 28 as detailed above.

Proposed: Niamh Collins
Carried without dissent

Seconded: Lawrence Kenna

Protocol 37: Interfacility evaluation/transfer is a new protocol which will be reviewed when the new software becomes available.

The sub group identified a difficulty with the PHECC interfacility patient transfer standard in relation to the computer aided dispatch (CAD) system. The CAD has three stacks, AS1 (999 or health care professional - emergency incidents), AS2 (Healthcare professional - urgent admission) and AS3 (Non urgent planned transport). Calls are prioritised within each stack based on pre-determined criteria, however the three stacks are not integrated. The calltaker allocates each call to a specific stack based on information received. If Protocol 37 is used for all interfacility patient transfers a routine patient interfacility transfer could get higher priority than an urgent admission. To overcome this issue the sub group recommends that;

1. Protocol 37 be utilised for 'time critical' interfacility patient transfers only. This will enable them be captured on the highest priority (AS1) stack and compete for available resources.
2. Protocol 37 not be utilised for 'non time critical' interfacility patient transfers. They should be captured on the lowest priority stack (AS3) and be allocated an appropriate time frame and resources.

Resolution: That MAG approves recommendations 1 & 2 in relation to Protocol 37 when it is introduced.

Proposed: Declan Lonergan

Seconded: Martin O' Reilly

Carried without dissent

Configuration definitions - 9 Cardiac respiratory arrest/death.

In light of experience outlined from DFB the sub group recommends that 9 B - Obvious death unquestionable discription activation code under 'Cold and stiff in a warm enviornment' be changed from 'Yes' to 'No'

Resolution: That MAG approves the amendment to the configuration definitions as detailed above.

Proposed: Declan Lonergan

Seconded: Martin O' Reilly

Carried without dissent

9.2 Field Guide

The issue of a PHECC produced field guide was raised by Niamh Collins. The meeting was advised that there are several field guides in use by Advanced Paramedics, in particular. Some are off the shelf and some are home produced. The off the shelf field guides, though well produced in the main, relate to other jurisdictions and contain skills and medications that are not compatible with Irish CPGs. Both Niamh Collins and Martin O' Reilly advised the group that some of the home produced field guides in circulation contain inaccuracies.

The advantages of a PHECC field guide were discussed. The meeting concluded that it would help to eliminate medication errors, particularly for paediatric doses and infrequently used medications. It would also act as a quick reference for Practitioners to check values such as GCS, MEWS, PEFR etc. An important advantage of a PHECC produced field guide is that it would ensure that currency of the information is maintained. Brian Power was formally requested by MAG to look into producing a PHECC field guide.

The next MAG meeting will be held on Thursday 9th September 2010 in the PHECC office Naas at 1.30pm. There being no further business the meeting concluded.

Signed: _____

Date: _____

Medical Advisory Group

Meeting Minutes 30th March 2010

Present:

Cathal O'Donnell (Chair)
Peter O'Connor
Martin O'Reilly
Lawrence Kenna
Valerie Small
Michael Garry
Macartan Hughes
Declan Lonergan
Mark Doyle
Sean Walsh

Apologies:

Stephan Cusack
Zelie Gaffney
David Janes
John O'Donnell
Fergal Hickey
Frank O'Malley
Brendan Whelan
Niamh Collins

In Attendance:

Geoff King (Director)
Brian Power
Deirdre Borland

1. Chairs Business

The Chair welcomed the assembled members to the March MAG meeting.

2. Minutes and Matters Arising

Resolution: That the minutes from the Medical Advisory Group meeting of 4th February 2010 be approved.

Proposed: Valerie Small

Seconded: Macartan Hughes

Carried without dissent

3. Citizen CPR

Deirdre Borland gave a presentation to the MAG members on the planned Citizen CPR public awareness campaign which will promote compression only CPR to untrained bystanders who witness the sudden collapse of an adult.

There was widespread praise for the initiative and the excellent work by Deirdre.

4. End of Life (DNR) CPG – Delphi

Results of the End of Life (DNR) CPG Delphi were circulated. Discussion ensued regarding the definition of “basic airway maintenance”, and “recent & reliable”.

Mark Doyle questioned as to why the clinician at the institution could not sign any required documentation for a planned transport.

It was suggested that the future “ideal” would be an official form that would be standard use for GP practices and institutions throughout the country.

It was suggested that the words 'do not resuscitate' be removed from the title of the CPG.

'Basic airway maintenance as required' be changed to 'Basic airway maintenance'

'Consider oxygen therapy' be changed to 'oxygen therapy'

It was suggested that the CPG be split in to areas higher up the flow chart, (i) Planned Transport with written confirmation of DNR status, (ii) 999 calls with recent and reliable evidence of DNR.

'Consensus' be changed to 'agreement' in relation to practitioners and caregivers on site and DNR.

Similar changes are to be made to the EMT level CPG.

Brian Power will make the recommended changes and bring back to the next meeting.

5. Bougies and Stylets for AP Practice

Brian Power informed the group that he has received a request from Niamh Collins seeking clarification from MAG as to the role of bougies in AP practice.

Declan Lonergan indicated that although bougies were included in the AP kit in the South East they are not a frequently used item.

Sean Walsh cautioned that if the airway was sufficiently difficult to merit the use of stylets and bougies that the patient requires the attention of an Anesthesiologist.

It was suggested that should an AP not be able to intubate they should proceed to use a supraglottic airway.

The use of stylets and bougies was therefore not recommended for AP practice currently.

6. Pandemic CPG

Brian Power informed the group that he had made contact with the HSE regarding getting their input for this CPG. HE is still waiting their response and will revisit the issue at a future meeting.

7. AOB

7.1 3rd Edition CPG Implementation

The issue of Practitioners who have been trained and examined to 3rd level CPGs but were not authorised to use them due to operational/training matters within their respective organisations was discussed. Michael Garry indicated that this was an issue that could potentially cause an ethical and legal risk to organisations effected. It was agreed that once a practitioner is appropriately trained to use a CPG and the medications and equipment is available to implement the CPG, the practitioner should be authorised by his/her respective organisation to utilise the CPG in his/her clinical practice as soon as practical. The Chair suggested that the Medical Advisors and Chief Ambulance Officers be urged to resolve this issue in each area. Macartan Hughes undertook to inform the Medical Advisors of the issue.

7.2 Infectious Disease – Blood Borne Disease

Mark Doyle sought clarification as to what procedures are in place regarding Practitioners and the transmission of blood borne diseases, as the potential for injury is quite high in pre-hospital

scenarios. It was suggested that the CPGs be compared with the HSEs Recommendations of the Report on The Prevention of Transmission of Blood Borne Diseases in the Health Care Setting. This issue will be discussed at the next MAG meeting.

7.3 Field Guide

Declan Lonergan asked as to the progress of the Practitioner Field Guide. The Director informed him that other priorities placed its development on hold at the moment.

The next MAG meeting will be held on Thursday May 27th in the PHECC office Naas at 10.30am

Signed: _____

Date: _____

Medical Advisory Group Meeting Minutes
Hodson Bay Athlone, 4th February 2010, 18:00

In Attendance:

Cathal O'Donnell (Chair)
Zelie Gaffney
Martin O'Reilly
Macartan Hughes
Frank O'Malley
Mark Doyle
Valerie Small
John O'Donnell
Paul Lambert
Niamh Collins

Apologies:

Lawrence Kenna
Michael Garry
Sean Walsh
Brendan Whelan
David McManus
Stephan Cusack
David Janes

Present:

Geoff King (Director)
Brian Power
Ricky Ellis
Deirdre Borland

1. **Chair's business**

The Chair welcomed the group to Athlone and thanked them for their attendance.

2. **Meeting Report – 14th December 2009**

Resolution: That the minutes from the Medical Advisory Group meeting of 14-12-09 be approved.

Proposed: Valerie Small
Carried without dissent

Seconded: Macartan Hughes

3. **Workshop Review:**

The Chair thanked those involved in the Clinical Review Tools Review and Dr. Georges Boussignac for their presentations given to the Committee prior to the commencement of the MAG meeting.

4. **Terminal illness do not resuscitate (DNR) CPG**

Brian Power introduced a Terminal illness - Do not resuscitate (DNR) CPG. The current "Recognition of Death" CPG is not specific enough to give direction to Practitioners who witness the cardiac arrest of a patient in end stage terminal illness. Also a private ambulance operator approached PHECC as their EMT level staff were engaged in the transport of patients in end stage terminal illness and have anticipated difficulties regarding DNR for such patients. PHECC

has developed two CPGs to assist with decision making for DNR; one CPG for Paramedic/Advanced Paramedic and a second CPG for EMTs, which is more strict in that it requires the EMT to have written recent confirmation of DNR status from a clinical source.

A discussion ensued regarding the definition of “recent”, “reliable” and “clinical source”. Macartan Hughes asked for clarification as to “caregiver” as this could include anyone from home help to family. He also expressed a concern that agency nurses etc may be not have a sufficient level of familiarity with the patient’s case history to make decisions regarding DNR status. In addition, the use of “continue transport to location” may be inappropriate if the patient passed away en route the end destination is home.

Valerie Small suggested that the CPG be titled “end of life” rather than terminal illness. The Director reassured the group that an element of flexibility will remain for the practitioner i.e. if in doubt commences resuscitation attempts. Brian Power stated that he would consult with interested parties prior to progressing further with the CPG. The Director suggested that the MAG under take a Delphi process to allow members to review and provide feedback.

5. EMS Priority Dispatch Standard

The Director informed the Committee that the EMS Priority Dispatch Standard has been finalised except for Protocol 36 and gone to the HSE and DFB for implementation. Protocol 36 relates to special arrangements that are introduced following medical advice during an influenza pandemic. Brian Power stated that a meeting was sought with HSE to discuss the draft recommendations of protocol 36.

6. Respiratory Pandemic CPG/ Influenza treat & refer CPG

Brian Power introduced the updates Influenza treat & refer CPG which was included in the meeting papers. As requested at the last MAG meeting the CPG now includes a introductory rationale on the reasons for this CPGs implementation. Mark Doyle questioned the appropriateness of potentially not transporting a 13 year old; legally a minor. It was suggested that a more appropriate age be 16 years. The Director undertook to seek guidance from the HSE.

7. Medication Formulary Updates to Medication Formulary (Amiodarone & Dextrose)

Brian Power asked that MAG recommend that the Medication Formulary be amended to allow for Amiodarone to be mixed with 5% Dextrose rather than NaCl as pharmacologically it serves as a better medium.

Resolution: That the Medical Advisory Group recommends the new version of Amiodarone medication formulary as presented in the meeting papers.

Proposed: John O'Donnell

Seconded: Valerie Small

Carried without dissent

Resolution That MAG recommends the Dextrose 5% medication formulary as presented in the meeting papers.

Proposed: Macartan Hughes

Seconded: John O'Donnell

Carried without dissent

8. **A.O.B.**

Brian power circulated an information guide to "Heart Mate" a left ventricular assist device. This device is currently fitted in 3 people in Ireland. CPR is not recommended for patients who have been fitted with the Heart Mate. Lawrence Kenna asked that this device be brought to the attention of the group.

COPD alert card is in the process of being developed for Irish use by the Irish College of General Practitioners.

The next meeting of the Medical Advisory Group will be held in Naas on Tuesday March 30th at 10.30am.

Signed: _____

Date: _____

	Responders No change
ALS 64 Neuroprotective Therapy	Practitioners No change
	Responders No change

Resolution: That the MAG approve PHECC recommendations relating to Part 8 – Advanced Life Support.

Proposed: Valerie Small
Carried without dissent

Seconded: Peter O’ Connor

8. A.O.B.

Frank O’ Malley enquired whether there was any further training planned for paramedics to increase their scope of practice. The Chair indicated that he would be interested in getting specific feedback and asked that Frank O’ Malley bring further details to the next meeting for consideration.

The Chair thanked the group for their attendance and Brian Power wished members a happy Christmas.

The next MAG meeting will be held in the PHECC office Naas, date to be advised.

Signed: _____

Date: _____



**Medical Advisory Group meeting
14th December 2009,
Tullamore Court Hotel**

Present

Cathal O'Donnell (Chair)
Valerie Small
Mark Doyle
Macartan Hughes
Brendan Whelan
Lawrence Kenna
Declan Lonergan
Paul Lambert
Sean Walsh
Frank O'Malley

In Attendance

Geoff King (Director)
Brian Power
Ricky Ellis
Jacqueline Egan
Deirdre Borland

Apologies

Gerry Bury
Martin O'Reilly
John O'Donnell
Niamh Collins
Conor Egleston
David McManus
Zelie Gaffney
Stephen Cusack
Peter O'Connor

1. Chairs Business

The Chair welcomed the group to Tullamore and thanked them for their attendance.

2. Minutes and matters arising

Resolution: That the minutes from the Medical Advisory Group meeting of 03-11-09 be approved on the addition of Gerry Bury to attendees list and that it is specified that H₁N₁ was the respiratory illness discussed in regard to vaccine take-up.

Proposed: Valerie Small
Carried without dissent

Seconded: Macartan Hughes

3. Draft Interfacility Patient Transfer Standard

The Director spoke to the Draft Interfacility Patient Transfer Standard which was approved by Council subject to the recommendation from MAG. The Director thanked the group for their work in finalising the standard.

The Chair suggested that Level 2 should include the definition – Acute non-emergent care, time not critical. And Level 3 should include the definition – Acute emergent care, time critical.

Resolution: That MAG recommends the Interfacility Patient Transfer Standard subject to the inclusion of;

Level 2 should include the definition – Acute non-emergent care, time not critical.

Level 3 should include the definition – Acute emergent care, time critical.

Proposed: Valerie Small
Carried without dissent

Seconded: Paul Lambert

4. EMS Priority Dispatch Standard

The Chair complimented those who contributed to the development of the Standard which will be an important tool is the targeting of ALS assistance. A list of determinants was tabled to MAG members. The chair asked the group to review the standard and to give their feedback which will be reviewed by Mark Doyle, Brian Power and the Chair.

Sean Walsh highlighted the importance of keeping the coding consistent between categories.

The Director undertook to consult with Brian Haskins/the HSE on the Flu Pandemic protocol to ensure of commonality approach.

The AMPDS Interfacility protocol will be examined further to confirm or otherwise the decision not to activate it.

Resolution: That MAG approve the EMS Priority Standard, Special Definitions and the DCR Reference Code subject to resolution of any feedback received by Tuesday December 15th at 17:00.

Proposed: Declan Lonergan
Carried without dissent

Seconded: Brendan Whelan

5. Aid to Capacity

An introduction to capacity evaluation was included in the meeting papers; background materials for same were tabled.

Sean Walsh suggested that the term “mental capacity” be used in lieu of “capacity”. Mark Doyle suggested that as are a lot of practical educational consequences to the implication of this item an algorithm could be developed. The Director undertook to develop a capacity tick box for the Patient Care Report, an algorithm and background learning standards/objectives.

6. A.O.B.

a. Respiratory Pandemic CPG

The draft Respiratory Pandemic CPG was tabled in the meeting papers. The Director welcomed the CPG which will cover any type of respiratory pandemic in a simple 3 line format. An introductory paragraph will be included to put the use of this CPG in context. Lawrence Kenna requested that the term “volumetric” be replaced with the universal term “spacer”. The amended CPG will be reviewed at the next MAG meeting.

b. Pandemic Treat & Discharge

At the last MAG meeting feedback was sought regarding this treat and discharge CPG. Macartan Hughes asked that the “Refuse” box be removed. Sean Walsh was unhappy with the mews system indicated and suggested that all children under 14 must be transported. It was also suggested that the word “admission” to changed to “transport to hospital”, and to change “refer” to “transport”. Macartan Hughes also asked that BMI be removed. The Director undertook to engage Brian Haskins/the HSE to ensure commonality of approach.

c. Paediatric Weight Calculation

Infants under 1 year old were omitted from the Paediatric Weight Calculation in the 3rd Edition CPGs. Niamh Collins asked that MAG resolve this.

Resolution: That MAG approve the Paediatric weight calculation for under 1s as follows. 3.5kg = Newborn and 6.5kg = 6 month old.

Proposed: Brendan Whelan
Carried without dissent

Seconded: Sean Walsh

d. DNR Terminal Patients

A discussion was held regarding the use of do not resuscitate orders when caring for patients at the end stage of a terminal illness. The chair said that as the CPG only applied to P and AP levels it did not assist EMT working particularly in private ambulance companies whom may be engaged in the provision of palliative care transport services. In light of new guidelines from the Medical Council it was agreed that this item be included on the agenda for the next MAG meeting.

e. CPG Field Guide

Declan Lonergan asked if PHECC plan to develop a pocket field guide for practitioners. The Director informed the group that Brian Power is in the process of developing a guide but it is not a priority project for the office at this time.

f. Patient Care Documentation

The Director indicated that PHECC will be requesting data from Patient Care Documentation as the quality of information needs to be evaluated. There was a suggestion from the regional representatives on the MAG that there is an issue in some cases with completion rates and quality of completion.

The Chair expressed a concern that if information being received in the ED, on which clinical decisions are being based is not reflective of care given, an unacceptable threat to patient safety is posed. The Director stressed that this highlights the need for an audit of patient care documentation, which will be undertaken as a matter of urgency. *Various contributors* will be invited to the next meeting to present on their experience with reviewing patient care documentation.

The next meeting of the Medical Advisory Group will be held on 4th Feb 2010 in the Hodson bay Hotel, Athlone to coincide with the AAP conference.

Signed: _____

Date: _____

MAG Meeting Minutes
3rd November 2009
The NASC, Phoenix Park.

Apologies:

Michael Garry
Stephen Cusack
Connor Egleston
Fergal Hickey
Mark Doyle
(N.A.S)

Present:

Cathal O'Donnell (Chair)
Paul Lambert
Zelie Gaffney
Niamh Collins
Valerie Small
Macartan Hughes
Frank O'Malley
Sean Walsh
Declan Lonergan
Peter O'Connor
Lawrence Kenna
Martin O'Reilly
Gerry Bury

In Attendance:

Geoff King(Director)
Brian Power
Ricky Ellis
Deirdre Borland
Frank McClintock
Brian Haskins (N.A.S)

7. Chairs Business

The Chair welcomed Sean Walsh, Consultant in Emergency Paediatric Medicine to the group. He also welcomed Frank McClintock and Brian Haskins from the HSE National Ambulance Service to the meeting.

8. Minutes and matters arising

Resolution: That the minutes from the Medical Advisory Group meeting of 24-09-09 be approved.

Proposed: Valerie Small

Seconded: Zelie Gaffney

9. Draft Patient Interfacility Transfer Code

Frank McClintock presented to the Group the current conditions and procedures the National Ambulance Service (NAS) and Health Services Executive (HSE) vis-à-vis interfacility patient transports.

The Director gave an overview of PHECCs relationship with Private Ambulance companies and clarified MAGs role and responsibility to concentrate on the clinical aspects of the Draft Interfacility Transfer Code.

The group held an extensive discussion as to the ideal clinical level for a variety of acuity levels.

Resolution: That MAG approved in principle the previous draft Interfacility Transfer code for presentation to Council, subject to the definitions of acute care being reworded and agreed with the Chair, Director and Frank McClintock.

Proposed: Peter O'Connor

Seconded: Macartan Hughes

10. AMPDS

Brian Haskins from NAS gave an overview of the Computer Aided Dispatch system AMPDS and in particular the algorithm (protocol 36) for patient categorisation in the case of an officially enacted pandemic /epidemic outbreak.

Resolution: That "Protocol 36" be approved in principle should pandemic /epidemic outbreak be enacted by the Director of Public Health, Medical Advisor and Chief Ambulance Officer on the condition that a follow up call be made within four hours to those not transported.

Proposed: Macartan Hughes

Seconded: Zelig Gaffney

11. Respiratory Pandemic CPG

The draft pandemic CPG was circulated in the meeting papers and discussed. Following issues

- For Mild to Moderate bronchospasm the use of metered aerosol salbutamol via volumiser is ok – but not for critical/ life threatening asthma.
- Zelig Gaffney suggested nebulise on scene rather than in ambulance where practical.
- Training implications re meter dose inhaler & volumiser.
- Gerry Bury stated that the use of appropriate P.P.E. and vaccine take up will nullify any major risks.

Resolution: 'Nebulisation not permitted' to be replaced. If option 2 invoked, meter dose inhaler & volumiser ok for mild moderate cases. Nebulisation permitted for severe or life threatened patients. Delete option 3 'Endotracheal intubation not permitted'

Proposed: Zelig Gaffney

Seconded: Niamh Collins

12. Influenza Treat & Discharge/Referral CPG

The draft treat & discharge/referral CPG was circulated in the meeting papers and discussed.

Niamh Collins asked that shortness of breath be removed from symptoms box and for it to be added to the 2nd box.

A discussion ensued regarding Oseltamivir administration. It was agreed that "consider ALS" and Oseltamivir be removed.

Niamh Collins asked that the amended mews score be lowered from 6 to 3. Also that the Paediatric dose for NaCl and Paracetamol be included.

Resolution: The amendments as outlined be made and the draft updated CPG be circulated to MAG members for approval. If no negative feedback is received within a specified timeframe the Chair of MAG should sign off the CPG.

Proposed: Macartan Hughes
Lonergan

Seconded: Declan

13.A.O.B

There are potentially three different AMPDS priority and dispatch criteria currently in Ireland (S.E., Midlands and D.F.B.) It was agreed that it is appropriate for MAG to agree a National Standard that can be implemented throughout the country. Declan Lonergan, Mark Doyle, Robert Morton, Peter O'Connor, Martin O'Reilly, Richard Lynch and Brian Power will review AMPDS priority and dispatch criteria to present a draft national policy.

The next MAG meeting will be held in Tullamore on December 10th 2008.

Signed: _____

Date: _____

The Medical Advisory Group Draft Meeting Minutes
24th Sept 2009-09-25
The Old Ground Hotel Ennis

Present:
Cathal O'Donnell (Chair)

In Attendance:
Geoff King

Apologies:
Lawrence Kenna

Zelie Gaffney
Niamh Collins
Macartan Hughes
Declan Lonergan
Mark Doyle

Ricky Ellis
Brian Power
Deirdre McHugh

Paul Lambert
David Janes
Michael Garry
Gerry Bury
Martin O'Reilly
Valerie Small
Stephen Cusack
Conor Egleston
Fergal Hickey
John O'Donnell
Peter O'Connor
Frank O'Malley
Brendan Whelan

1. Chairs Business

The Chair welcomed the group and thanked them for their attendance.

2. Minutes and Matters arising

The Chair outlined the contents of a letter from IAMI President Fergal Hickey which informed the MAG that the IAMI has formed a subcommittee to suggest recommendations regarding medical standards at events. A formal response can be expected by January 2010.

Zelie Gaffney suggested that G.P's should also be approached for feedback and suggestions as they provide medical cover at many events throughout the country. The Director explained that PHECC is developing an initial framework and that wide consultation would occur after that.

Resolution: That the minutes from the Medical Advisory Group (MAG) Meeting of 28th May 2009 be approved.

Proposed: Declan Lonergan

Seconded: Mark Doyle

3. Pandemic CPG

The Chair informed the group that advice was sought from Kevin Kelleher regarding the development of a Pandemic CPGs.

The draft pandemic CPG was circulated in the meeting papers and discussed. The appropriateness of not permitting nebulisation was an issue raised.

The Director stressed the importance of providing clear definitive guidance and suggested a scaled response dependent on likely outcome may be prudent.

The Chair will contact Brian Haskins from the National Crisis Management team and report back at the next meeting.

A Draft Influenza treat and referral/discharge CPG was tabled for initial review, following contact from Brian Haskins who represents the HSE Ambulance Service

on the National Pandemic team. The chair suggested that this be reviewed and discussed at the next meeting.

4. Citizen CPR

The draft key message for the Citizen CPR campaign was discussed. The Director asked the group for their opinion on the importance of specifying if the collapse was witnessed or unwitnessed. The group agreed that in the interest of keeping things simple and preventing any delay in the commencement of compressions witnessed or unwitnessed should be unspecified.

Mark Doyle suggested that the use of the word unresponsive may cause confusion for a lay person and a phrasing such as “if someone collapses, is unconscious and has stopped or almost stopped breathing” may aid the interruption of the message.

5. Supraglottic Airway Devices

The Delphi feedback from MAG members regarding the ideal characteristics of a supraglottic airway device was discussed.

Niamh Collins suggested that the large number of neutral scoring may be due to unfamiliarity with all of the products.

The Chair suggested that devices be made available at the next MAG meeting where the members will get the opportunity to use the devices and re submit their Delphi feedback.

Mark Doyle suggested that crew’s feedback would to also a good source of feedback to move forward.

6. Mechanical CPR Device

The Delphi feedback from MAG members regarding the ideal characteristics of a mechanical CPR device was discussed.

As per the Supraglottic airway device The Chair suggested that a skills lab will be arranged to after the next MAG meeting where the members will get the opportunity to use the devices and re submit their Delphi feedback.

7. Draft Patient Interfacility code

The draft interfacility transport code was discussed at length. Particularly, the need to have paramedic level practitioner present in the rear of the vehicle where hospital staff are accompanying a patient. It was also stated that for unstable acute care, two persons’ of at least Paramedic level should accompany the patient in the saloon of the ambulance.

The Director will revise the code and it will be on the agenda for the next meeting.

8. Treat and Referral/Discharge CPG

Draft treat & referral/discharge CPGs were circulated in the meeting papers. The Director stressed the importance of cooperation and communication between the Practitioners and local G.Ps as this is a mutually beneficial development.

Zelie Gaffney indicated that G.Ps are currently working to maximum capacity in many regions and this needs to be considered in the roll out in any such scheme.

Ricly Ellis questioned the appropriateness of the use of “Alcohol Taken” on the CPG. It was also suggested that a socially vulnerable category be added to the exclusion criteria.

The Chair indicated that the capacity to evaluate should be formalised before focusing on individual CPGs. It was agreed that the Chair, Director and Brian Power will research the area of “capacity” and report back to MAG.

The group indicated that “angina” not be included treat & referral/discharge CPGs. The mild bronchospasam treat & referral/discharge CPG be changed to exclude the discharge route.

9. A.O.B

The Director informed the group that all regulators have been asked to encourage their members to take up the H₁N₁ flu vaccine. A draft letter from the registrar to all registrants was read and the group agreed that its circulation is prudent.

Brian Power tabled a Medical Practitioner level CPG for Cardiac Chest Pain – Acute Coronary Syndrome for approval.

Niamh Collins raised a concern regarding the point at which Clopidogrel is indicated at AP level as per the Cardiac Chest Pain – Acute Coronary Syndrome CPG. The chair stressed that the point at which Clopidogrel is administered should be taught in the course of A.P training

Resolution That the MAG approve CPG(M) Cardiac Chest Pain – Acute Coronary Syndrome

Proposed: Zelie Gaffney

Seconded: Mark Doyle

Fluid Replacement CPG

The chair stated that Prof. Gerry Bury had informed him that there is a request for a CPG for fluid replacement for those in hypovolemic shock.

The Director and Brian Power will look into this and report back to MAG at the next meeting.

IO Route

A concern was raised that A.Ps may be over cautious and unsure of the acceptability to use of the I.O route. The Director suggested that the A.Ps be communicated with to give reassurance where needed. He also suggested the development of a forum where practitioners can ask questions and discuss CPGs. This would be a useful tool in communicating with registrants. It was agreed that this issue be put on the agenda for the next meeting.

DNR – EMT

A request from Lifeline Ambulance Ltd to examine the current situation regarding DRN at EMT level was discussed. It was agreed that it be put on the agenda for the next meeting.

Field Guide

Declan Lonergan asked if there were any plans to develop a practitioner field guide as it would enhance medication safety. The Director informed him that the rationale for a national field guide was being prepared by Brian Power

Next Meeting

The next MAG meeting will be held on 3rd November in Dublin (venue TBA)

**Medical Advisory Group (MAG) meeting minutes
28th May 2009
The PHECC office, Naas**

Present:

Cathal O'Donnell (Chair)
Paul Lambert
Brendan Whelan
Mark Doyle

In Attendance:

Geoff King
Brian Power
Deirdre Borland
David McManus

Apologies:

Declan Lonergan
John O'Donnell
Fergal Hickey
Conor Egleston

David Janes
Macartan Hughes
Michael Garry
Gerry Bury
Martin O'Reilly
Frank O'Malley
Lawrence Kenna
Valerie Small
Stephan Cusack

Zelie Gaffney

1. Chairs Business

The Chair welcomed the group and thanked them for their attendance. Apologies were given on behalf of absent members

2. Minutes and Matters arising

Resolution: That the minutes of the MAG held on 21/04/09 are passed subject to the correcting the 2 names absent from the attendance list, the correction of the spelling of the word border and correction of "metaclopramide".

Proposer: David Janes

Seconded: Michael Garry

Carried without dissent

3. Supraglottic Airways

Included in the meeting papers was a "gold standard" document regarding supraglottic airway devices. Brian Power asked for feedback from the group. The following points were raised:

- Stating criteria such as ease of use and evidence based details of likely success and failure rates.
- The importance of the device being known in a hospital environment.
- Details of weight appropriate sizing given on tube.

The Chair informed the group a Delphi process will define this standard which is being devised as an aid in the procurement process. It will be discussed in further detail at the next MAG meeting.

4. Mechanical CPR devices

Included in the meeting papers was a "gold standard" document regarding Mechanical CPR devices. Brian Power asked for feedback from the group. The following points were raised:

- Criteria for each region such as required running time should be considered.
- The benefit of a decompression function was questioned.
- Are there CEN compliant issues to consider?

The Chair informed the group a Delphi process will define this standard which is being devised as an aid to procurement process. It will be discussed in further detail at the next MAG meeting.

5. Pandemic CPGs

Brian Power introduced two potential Pandemic CPG's to the group, one as a "cover all" and one specific for instances of declared/threatened pandemic situations.

A discussion ensued as to whether a CPG is required to communicate this and if a statement may be sufficient. The importance of linking with agencies such as the HSE, Health Promotion, and WHO was stressed by a number of members.

Stephen Cusack suggested that a guidance statement such as “during declared/possible? Pandemics involving airborne pathogens, nebulisation and endotracheal intubation are prohibited and the wearing of appropriate PPE is compulsory.

Brian Power will liaise with Pat Doorley from Public Health and Kevin Kelleher from HPSC to seek advice and research this issue further.

6. Citizen CPR & CPR + course

The Director gave an account of work undertaken so far on these initiatives and outlined outstanding tasks.

The Chair congratulated PHECC on the work done to date on these projects. The draft programmes included in the meeting papers were discussed. Items considered included:

- Changing wording to “Irish Public” rather than “Irish Citizen”
- Changing wording to “Appropriate Care Experience rather than “Acute Hospital Experience”
- Amend “Appropriate PHECC Instructor” to “Appropriate PHECC Instructor or equivalent” to cater for those with recognised qualification other than PHECCs.
- Add “call for help” to CPR+ CPG. Also link to Airway Obstruction if 4-5 attempts of ventilation have failed.
- Under faculty state requirement as “certified Instructor”
- Where PHECC teaching material is provided stipulate that this must be used.

Technically of use of a paediatric attenuated AED is recommended for paediatric patients. A concern was raised that if an under 8 required defibrillation and only an “adult” AED was availability that a responder may not use it. It was suggested that this be included in the knowledge objectives and also reflected in relevant CPGs. The PHECC office will develop wording to this effect for the next MAG meeting.

A concern was expressed as to how the Citizen CPR programme will interface with the CFR Standard. The Director informed the group that preferably an individual would be CFR trained but in the absence of training or unwillingness to perform CPR, Compression only CPR is acceptable.

The Chair asked that this be added to the programme aim. Also that support materials be developed for this programme.

7. Cross Border Services Model

The Director informed the group that work is ongoing with the Northern Ireland Ambulance Service. The group will be informed of any developments at future MAG Meetings

8. Draft Interfacility Patient Transport Code

The Director tabled a draft Interfacility Patient Transport Code detailing the recommended clinical level for different grades of patient transport. This chart is being developed in light on heightened press regarding the private ambulance industry and concern for organisations exposure to vicarious liability. It is envisaged that this chart

would be distributed to healthcare facilities along with a information pack detailing practitioner skills, and medication matrices to aid the decision making process as to the clinical staffing requirements for a range of patient transports categories. The components of the chart were discussed at length and it was decided that this was a key project for the MAG to develop.

Resolution: That the MAG support in principle the development of the Interfacility Patient Transport Code

Proposer: Michael Garry
Carried without dissent

Seconded: Martin O'Reilly

9. Medical Standards at Events

The Chair asked for the group's thoughts regarding the development of a standard for clinical staffing and facilities at events.

It was suggested that voluntary and auxiliary groups and county councils who have experience of such events be engaged with to aid assessing the current situation. Stephen Cusack informed of a group in London who run a course specifically in "Event Medicine".

Brian Power will approach the Irish Association for Emergency Medicine for their opinion on this issue. This item will be discussed at the next MAG meeting

10. AOB

David Janes asked for an update on the current situation as to CPG edition 2/3 use and upskilling. The director gave an overview of both issues. The next to MAG meeting has been set for Tuesday June 23rd 10.30am PHECC office, Naas.

Signed _____

Date _____

Medical Advisory Group (MAG) draft meeting minutes 21st April 2009 The Ormond Hotel Kilkenny

Present:

Cathal O'Donnell (Chair)
Paul Lambert
Zelie Gaffney
David Janes

In Attendance:

Geoff King
Brian Power
Ricky Ellis
Deirdre Borland

Apologies:

Michael Garry
Gerry Bury
Mark Doyle
Fergal Hickey

Macartan Hughes
Peter O'Connor
John O'Donnell
Martin O'Reilly
Declan Lonergan
Frank O'Malley
Valerie Small
Brendan Whelan
Lawrence Kenna
Stephen Cusack

Paul Meehan
David McManus
Conor Egleston

11. Chairs Business

The Chair welcomed the group and thanked them for their attendance. He also extended a welcome to Mr. Paul Lambert, who has joined the Medical Advisory Group as a representative of Dublin Fire Brigade Training Institution.

12. Minutes and Matters arising

Resolution: That the minutes of the MAG held on 26/03/09 are passed subject to the correcting the wording of distension to dissent.

Proposer: John O'Donnell

Seconded: David Janes

Carried without dissent

13. Supraglottic Airways

The Chair gave an overview of the Airway Devices that were presented during the previous day's event. He also circulated a list of citations that was reviewed by the critical appraisal group. The Chair asked the group to review the material with the view to having an informed discussion at the next MAG meeting.

A discussion ensued as to the feasibility of conducting trials in an effort to discover suitable devices in the Irish pre-hospital setting. The practicalities of using specific brand devices in a training setting were also discussed. The Director suggested that evidence should be looked at on an ongoing basis to ensure that MAG's opinion is kept well informed and in line with the latest evidence.

Mr. Brian Power suggested that since the CPG's containing the phrasing "LT/LMA" they should be changed to "supraglottic airway" to allow for any new products/developments to the marketplace.

The group concluded that a Delphi process be formed to report the characteristics of an ideal supraglottic airway.

Resolution: The phrasing LT/LMA be changed to supraglottic airway on all relevant CPGs.

Proposer: Valerie Small

Seconded: David Janes

Carried without dissent

14. Cross Border Services Model

The Director reported on a meeting held between him and the UK Health Professional Council and the Northern Ireland Ambulance Service. The issues facing practitioners regarding drug administration when in a cross boarder situation were discussed. The Director informed the group that there are 3 drugs used by paramedics in Northern Ireland that are not included in the PHECC Medication Formulary; Metoclopramide, Chlorpheniramine, and Tramadol.

The Director informed the group that when this issue is resolved Ireland/Northern Ireland will be the 1st European region to legitimise cross boarder pre-hospital emergency services.

A discussion took place as to the prevalence of cross boarder activity between Ireland and Northern Ireland.

David Janes indicated that this would be an excellent step towards easing the concerns of practitioners in both jurisdictions. He also asked for reassurance that this would not affect the standards of entry to the PHECC register.

The Director confirmed that any initiative would only allow drug administration in defined circumstances and would not affect current requirements for PHECC registration.

15. Mechanical CPR Devices

The Chair informed the group that in light of the upturn in the deployment of solo responders mechanical CPR devices may be beneficial. He outlined the experiences of the Mid-Western Regional Hospital Limerick and the HSE Midwest division in the use of various mechanical CPR devices. A document detailing their findings was presented to the group. The Thumper® device was chosen as the best device to meet Midwest's requirements.

The Director suggested that MAG would be best placed to clarify the essential and ideal features of a mechanical CPR device as part of an evaluation process that would aid the procurement process for organisations considering the purchase of such devices.

John O'Donnell informed the group that the Lucas® device is currently successfully used in the Emergency Department of The University College Hospital, Galway. He did stress the need to examine the cost differentials and future proofing qualities of the various devices.

Stephen Cusack stressed that it would be difficult to find good research papers as to the clinical efficacy of mechanical CPR devices as their main value is one of convenience.

David Janes warned of the potential risks of MAG defining a "Gold Standard" while there are so many ongoing developments with medical devices.

It was pointed out that the introduction of mechanical CPR devices may lead to ethical issues vis-à-vis turning off the device and ceasing resuscitation.

The Chair suggested that the clinical review group conduct a literature review of the 3 devices on the market in Ireland and that reps be invited to a future MAG event to Display their products.

The group concluded that a Delphi process be formed to report the characteristics of an ideal mechanical CPR device.

16. CPG development

An EMT level CPG for COPD was presented for approval to the group by Brian Power. Stephen Cusack asked that the phrasing "inadequate ventilations" be changed to "adequate respirations" in COPD CPG at every level to avoid confusion.

Resolution: That the group approve the CPG for COPD at EMT level, subject to the change recommended above.

Proposer: Stephen Cusack
Carried without dissent

Seconded: David Janes

The Chair asked that a Pandemic CPG be devised in light of the Swine Flu threat. Brendan Whelan informed the group that there is an Ambulance Service policy document regarding panflus which he will circulate to the group. Brian Power offered to draft a Pandemic CPG and present it to the group at the nearest opportunity.

17. Citizen CPR

The director gave an overview of the development plan which is in its infancy. Wording of faculty may exclude GP's. It was agreed to rephrase as registered medical practitioners/nurses with appropriate experience.

The PHECC office will report back on any development with the Citizen CPR initiative.

18. AOB

Brian Power tabled a document regarding AED training for paediatric patients at CFR level. It is proposed that an add on module be made available to the CFR course for those who wish to undertake training in the use of AED on a child. All objectives were taken directly from the existing PHECC Education and Training Standards 2007. A practitioner at instructor level would be required to deliver this training. The group were asked to give their feedback to the PHECC office prior to the next meeting where a more informed discussion can be held.

Dates for the next to MAG meetings have been set for Thursday May 28th and Tuesday June 23rd

Signed _____

Date _____

Minutes MAG meeting March 26th 2009, PHECC office Naas

Present:

Mr. Cathal O'Donnell, Chair

Mr. Martin O'Reilly

In Attendance:

Dr. Geoff King

Mr. Brian Power

Apologies:

Mr. Connor Egleston

Dr. David McManus

Dr. Zelig Gaffney
Mr. Declan Lonergan
Mr. Brendan Whelan
Mr. Macartan Hughes
Dr. David Janes
Prof. Gerry Bury
Mr. Mark Doyle
Mr. Fergal Hickey (VC)
Ms. Valerie Small
Mr. Frank O'Malley

Mr. Ricky Ellis
Ms. Claire Finn

Mr. Tom Mooney
Mr. John O'Donnell
Mr. Stephen Cusack
Mr. Michael Garry
Mr. Lawrence Kenna
Dr. Peter O'Connor
Mr. Richard Lynch
Mr. Paul Meehan

1. Chair's business

The Chair welcomed the group and thanked them for their attendance.

1.1 CPG Weekend

The Chair noted that the seminar/weekend regarding CPGs for Airway Devices was a very useful and worthwhile exercise.

2. Minutes and Matters arising

Dr. David Janes pointed out that item 1.3.1 of the minutes of previous meeting does not accurately reflect the wording of the ACS CPG in relation to the timeframe for thrombolysis. A discussion ensued, where it was decided to accept the minutes subject to changing the wording to equate to that on the ACS CPG.

Resolution: *That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 17th February 2009 be agreed.*

Moved: Dr. David Janes

Seconded: Mr. Brendan Whelan

3. Development of Additional CPGs

Mr. Brian Power submitted the following CPGs for approval/review by MAG:

a. Anaphylaxis – Adult

Concern was raised about the dosage of Hydrocortisone, CPG states 300 mg IM, the meeting consensus was that 200 mg was more appropriate. Change pathway

decision wording from ‘Severe or recurrent reactions...’ to ‘Severe and or recurrent reactions....’ David Janes raised a concern about the definition of anaphylaxis. A discussion ensued about allergic reaction versus anaphylaxis. Change the pathway into the CPG from ‘Anaphylaxis’ to ‘allergic reaction’. Include IO as a route for Hartmann’s solution. CPG to be renamed “Allergic Reaction/Anaphylaxis” and the pathway information boxes in the CPG be renamed, “Mild”, “Moderate” and “Severe/Anaphylaxis”

Resolution: *CPG Allergic Reaction/Anaphylaxis - Adult be approved subject to the changes agreed above.*

Moved: Mr. Mark Doyle
Passed without dissent.

Seconded: Dr David Janes

b. Anaphylaxis – Paediatric (≤ 13 years)

The changes agreed with the Adult Allergic Reaction/Anaphylaxis were also agreed for the Paediatric version. The dose of Hydrocortisone for paediatrics was acceptable.

Resolution: *CPG Allergic Reaction/Anaphylaxis- Paediatric be approved subject to the changes agreed above.*

Moved: Mr. Mark Doyle
Passed without distension.

Seconded: Dr David Janes

c. Nausea and Vomiting – Adult

Concerns were raised regarding the appropriate use of this CPG and that it should not be for routine nausea. It was agreed that this CPG should only for use by Advanced Paramedics and the appropriate use should be covered in training (AP seminars, up-skilling training and AP Course). It was recommended that the draft CPG be renamed “Significant Nausea/Vomiting”. Dehydration and consider NaCl be deleted from the CPG. Add Cyclizine as an alternative to Ondansetron. The preferred route for these medications is IM, however if IV in situ this route was acceptable. Brian Power informed the meeting that the Medicinal Products schedule did not permit the IM route for these medications.

Resolution: *Significant Nausea/Vomiting CPG be approved subject to the changes agreed*

Moved: Mr. Declan Lonergan

Seconded: Dr. Zelig Gaffney

Passed without distension

d. Exacerbation of COPD

The availability of Capnography equipment on ambulances was discussed. As it is currently not standard equipment it was decided to delete all reference to this in the draft CPG. The SpO₂ level of 88% to 92% for COPD patients was debated and a decision was made to refer to 92% only. The dose of Hydrocortisone to equate to the dose agreed for the Anaphylaxis CPG.

Resolution: *CPG approved subject to the changes agreed above.*

Moved: Dr. David Janes **Seconded:** Ms Valerie Small
Passed without distension

3. Blood Glucose Levels for Paediatric – Hypoglycaemia

A concern raised by the clinical nurse specialist in the Diabetic Unit in UCHG on the blood glucose level for interventions for hypoglycaemia was discussed.

Resolution: *That the CPG for Paediatric Hypoglycaemia be amended to state “< 4mmol/L”*

Moved: Dr. David Janes **Seconded:** Mr. Macartan Hughes
Passed without distension

4. Diazemuls Ingredients that may cause allergies

Mr. Brian Power investigated concerns raised regarding the use of Soya and/or Egg Yolk ingredients in Diazemuls. Brian reported that he found no evidence of these ingredients being included in Diazemuls. It was agreed there was not an issue.

5. Modified Early Warning Score

Mr. Brian Power presented a draft updated modified early warning score (MEWS) that may be more appropriate for pre-hospital emergency care use. This was discussed at length by the group. Mr. Cathal O’Donnell suggested that this be investigated further using the data being collected by his department in Limerick in order to compare the outcomes against the proposed MEWS update. The MEWS as currently presented is not to be changed at this time.

6. Tabled documents

6.1 Citizen CPR

The group discussed the merits of developing a citizen CPR course. Such a course would be strip-down CFR course. The concept was to bring CPR to the masses and minimise assessment. Three options were presented; standard CPR, compression only CPR and CPR with AED. It was decided to promote compression only CPR for Citizen CPR and non certification of these courses. Two levels of course would be available one without AED and one with AED. The required level for instructors was discussed at length. It was agreed that for the safe use of AEDs that a CFR Instructor would be required to teach the Citizen CPR/AED course. Agreement was not reached on the requirements for a Citizen CPR Instructor.

The use of a poster campaign to promote Citizen CFR was supported.

6.2 PHECC CFR Standard – Paediatric

A concern raised by Bridget Sinnott (IHF), in relation to the availability of paediatric AED training was presented to the group. It was pointed out that paediatric AED training was available through the practitioner CFR course. Geoff King outlined that it is also available as an add-on (CFR+) although not well publicised. Cathal O'Donnell suggested that PHECC include a paragraph outlining the CFR+ in the Education and Training Standards for those who wish to avail of paediatric AED training and create a specific CPG to cover this at CFR Responder levels.

Resolution: *That AED for paediatrics be included as an optional add-on (CFR+) in the PHECC CFR Standard.*

Moved: Mr. Mark Doyle
Passed without distension

Seconded: Dr David Janes

The Chair thanked the group for their attendance

The next MAG meeting will be held on April 27/28th in the Ormond , Kilkenny at 10.00am

Chair:_____

Date:_____

Minutes MAG meeting February 17th 2008, PHECC office Naas

Present:

Mr. Cathal O'Donnell, Chair
Mr. Martin O'Reilly
Dr. Zelig Gaffney
Mr. Declan Lonergan
Mr. Brendan Whelan
Mr. Michael Garry
Mr. Macartan Hughes
Mr. Stephen Cusack
Dr. David Janes
Prof. Gerry Bury
Mr. Lawrence Kenna

In Attendance:

Dr. Geoff King
Mr. Brian Power
Mr. Ricky Ellis
Ms. Deirdre McHugh

Apologies:

Mr. Mark Doyle
Mr. Connor Egleston
Mr. Vincent O'Connor
Dr. David McManus
Mr. Tom Mooney
Mr. John O'Donnell
Ms. Valerie Small
Mr. Fergal Hickey
Mr. Frank O'Malley

1. Chair's business

The Chair welcomed the group and thanked them for their attendance.

1.2 Vice-Chair of MAG

The Director informed the group that Dr. David Janes has expressed an interest in the vacant role of vice chair. No further nominations were brought forward.

Resolution

That Dr. David Janes be appointed Vice-Chair of MAG.

Proposer: Mr. Macartan Hughes Seconded: Dr. Zelig Gaffney

1.3 Solo deployment of practitioners and drug administration

The Chair invited discussion on the issue of checking of medication prior to administration should a practitioner be responding to an incident in a solo capacity.

Prof. Gerry Bury had sought some advice which suggests there is some evidence that medication error is less in instances of solo administration. The general view was that it is a judgement call of the practitioner at the time to decide if it is the patient's interest to solo administer a medication, or to wait the arrival of assistance. If solo administration occurs, the practitioner should document same in the usual manner.

1.4 Acute Coronary Syndrome CPG

1.3.1 Thrombolysis in cases where receiving hospital is within a relatively short transport time.

Dr. David Janes expressed a concern as to why a practitioner should wait any length of time once the decision that thrombolysis would benefit the patient has been made. A discussion ensued regarding the benefits of immediate thrombolysis versus the potential risk of complications and how they would be managed in a pre-hospital environment

Resolution

Following 12 lead ECG interpretation, if anticipated time from STEMI recognition to handover to clinical staff in a hospital with thrombolysis capability is;

- 1. < 20 minutes – do not thrombolyse; initiate transport and pre-alert receiving hospital.*
- 2. > 30 minutes – thrombolyse, then transport to nearest appropriate hospital.*
- 3. 20 to 30 minutes – thrombolyse if considered that local circumstances may delay transport (practitioner discretion), then transport to nearest appropriate hospital.*

Proposer: Mr. Michael Garry Seconded: Mr. Declan Lonergan

1.3.2 What hospitals should a thrombolysed patient be transported to?

The group discussed the appropriateness of transporting a thrombolysed patient to a hospital other than the hospital that had provided on line advice to the Advanced Paramedic. The nearest appropriate hospital (with Emergency Department, Coronary Care Unit, Cardiology and/or PCI Laboratory) is where the patient should be transported to.

Resolution

The wording of “Patients should be transported to the nearest appropriate hospital” should be included on the Acute Coronary Syndrome CPG

Proposer: Mr. Stephan Cusack Seconded: Dr. David Janes

4. Minutes and Matters arising

Dr. David Janes asked for clarification regarding the paediatric weight calculation formula. Brian Power tabled a letter from the Advanced Life Support Group, who indicated that they will continue to use the $[\text{age} \times 2] + 8$ formula as they feel there is insufficient evidence to merit changing it.

Dr. David Janes called for discussion as to how the 2nd Edition CPGs are maintained and updated in light of the timeframe for training and implementation of the 3rd Edition CPGs. The Chair recommended that the 2nd and 3rd Edition CPGs be put on the MAG agenda on an ongoing basis.

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 11th December 2008 be agreed.

Moved: Mr. Michael Garry

Seconded: Dr. Zelig Gaffney

7. Minimum Age for using a Defibrillator

Mr. Brian Power indicated that there had been a number of queries to PHECC as to what is the minimum age to be trained in the use of a defibrillator. Dr. Zelig Gaffney indicated that she felt Transition Year students were well placed for learning the necessary skills and understanding the safety issues involved. She also suggested that seeking parental consent prior to training may be prudent. A discussion took place whether competence or age should be the defining factor when deciding who to train in the use of a defibrillator.

Resolution:

That the following guidelines should apply regarding minimum age for defibrillation: "Fundamentally, an individual should be mature enough to comprehend the knowledge, skills and implications associated with defibrillation. Currently, training institutions recognised by PHECC use 16 years old as a benchmark."

Moved: Dr. Zelig Gaffney

Seconded: Dr. David Janes

8. Advanced Airway Management.

The group discussed the recently published paper by JRCALC and the response by the British Paramedic Association, on endotracheal intubation. Various perspectives were outlined.

The Chair suggested that the MAG meeting to be held in April focus on airway management and the manufacturers of Supraglottic Airway devices be invited to present on their products. Also that Mark Dixon an Advanced Paramedic, be asked to present on his research on these devices as it is the focus of his masters dissertation.

Quality Assurance/Clinical Audit

Mr. Stephen Cusack indicated that he felt as the numbers of practitioners providing advanced skills is increasing, MAG should have procedures in place to ensure standards are being maintained.

Resolution: *That MAG writes to Council to highlight the need for implementation of Clinical Audit/Quality Assurance and to emphasise concern that these standards have not been adequately developed nor implemented.*

Moved: Dr. David Janes

Seconded: Mr. Mick Garry

5.1 Use of Drugs to prevent motion sickness while in transit

A case study by Paramedic Michael Donnellan outlining an instance of motion sickness in a patient travelling a long distance was presented. He also detailed the prevalence of this experience in remote areas. Mr. Donnellan requested that use of antiemetic medications be extended to cover this situation in a CPG.

Dr. Janes suggest that the latest evidence be reviewed

Brian Power to look at the side effects of the medications involved and to draft a CPG to cover this situation.

5.2 Use of Pepper Spray by Gardaí

The Chair informed the group that there are proposals that An Garda Síochána will be permitted to use pepper spray in the near future. He suggested that contact should be made with the Garda CMO on the issue and a CPG should be drafted for the treating of those exposed to pepper spray.

6 Diazemuls

Mr. Brian Power informed the group that a question had been submitted to PHECC regarding the administration of Diazemules to patients with egg or soya allergies. The Chair suggested that the Material Data Safety Sheet for Diazemules be checked before MAG makes any decisions on this issue.

**Meeting Report of the PHECC Medical Advisory Group held at the PHECC office
Naas on Tuesday 6th May 2008**

Present:

Mark Doyle
Fergus McCarron
John Burton
Gerard Bury
David Janes
Sean Creamer
Macartan Hughes
Lawrence Kenna
Martin O'Reilly
Declan Lonergan
Peter O'Connor

Apologies:

Stephen Cusack
Paul Robinson
Julie Woods
Conor Egleston
Cathal O'Donnell
Vincent O'Connell
Fergal Hickey
David McManus
Michael Seaman
Stephen Cusack
John O'Donnell

In attendance:

Brian Power
Deirdre McHugh

1. Chair's Business and apologies:

The Chair thanked the group for their apologies and made apologies for the late start.

2. Meeting Report and matters arising

2.1 Meeting Report 30th January

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 30th January 2008 be agreed.

Moved: Macartan Hughes

Seconded: Sean Creamer

Subject to the amendment of typo on Page 2 (spelling of Meningococcal)

2.2 Matters arising

2.2.1 Penicillin Allergy

Davis Janes asked that “intolerance to penicillin” be changed to a “severe allergy” with a definite history.

3. Medication Formulary

Brian Power informed the group that a Professor of Pharmacology in University College Cork has agreed to externally review the Medication Formulary after The MAG has carried out their own analysis.

Prof. Gerard Bury raised a concern that many of the drugs featured in the Medication Formulary have long and short term side effects that should be considered by the Practitioner as part of their treatment of a patient.

Proposal: that a side effects (immediate and those resulting from long term use) be listed as part on the Medication Formulary for appropriate medication.

Proposer Prof. Gerard Bury

Seconded Mr Fergus McCarron

Carried without dissent

The group then reviewed each section of the Medication Formulary and suggested amendments.

A concern was raised by Sean Creamer regarding the situation where a paramedic had an issue with taking over a patient with an IV that had been established by a Doctor or Advanced Paramedic. The group concurred that the responsibility of the paramedic was purely to maintain the IV and therefore there should not be any grounds for objection.

The group suggested various amendments to wordings such as the Standardisation of “Known Severe Adverse Reaction”, the inclusion of the associated CPG(s) number in the indications field and the amendment of Head Injury to Brian Injury.

Proposal: the Medication Formulary is approved by MAG subject to the changes listed.

Proposer Declan Lonergan

Seconded Mr John Burton

Carried without dissent

Medication	Section	Changes
Amiodarone	Usual Dosages	“one” to precede supplemental dose
Atrophine	Usual Dosages	To include:

Summary of Changes to Medication Formulary

		Organophosphate Poison – repeat at 3-5 min intervals to ensure minimal salivary secretions. Paediatric: 0.02mg/kg repeat x 1 at 3-5 min interval prn.
Benzylpenicillin	Administration	Include IV/IM/IO
Clopidogrel Tablets	Presentation	Include 300mg tablet if available
	Indications	"Acute" to precede Myocardial Infraction
Dextrose 10% Solution	Administration	Amend typo to IO (IV duplication). Add "Paramedic maintain infusion once commenced"
	Usual Dosage	Add IO
Diazepam Injection	Administration	Amend typo to IO (IV duplication).
	Usual Dosages	Amend 0.4mg/kg to "max 10mg or 0.4mg/kg whichever is the lowest".
Enoxaparin Sodium Solution	Usual Dosages	Prof. Bury to check recommend dose.
Epinephrine (1:1 000)	Administration	Remove "first choice in anaphylaxis"
	Additional Information	Remove "If Intravenous (IV) is indicated use 1:10 000"
Furosemide Injection	Presentation	Typo amend ml to ML
	Indications	Remove "following history of congestive heart failure" (change CPG to reflect this)
Glucagon	Usual Dosages	Typo amend >8 years
	Additional Information	Add prior use intravenous 24 hours
Hartmann's Solution	Additional Information	Add if possible.
Ibuprofen	Contra-indication	Add exacerbated by Aspirin
Lorazepam	Indications	Change to reflect CPGs
	Contra-Indications	Add "Significant alcohol and or sedative injection suspected"
Magnesium Sulphate Injective	Description	Remove "commonly called Epson Salts"
	Presentation	Change 5mg to 5g (CHECK THIS)
	Usual Dosages	bronchospasm: 1.5g IV/IO infusion over 20mins.
Midazolam Solution for Injection	Administration	Amend to IN (IN)
	Contra-Indications	Move "Shock, depressed vital signs or alcohol related altered level of consciousness" from Pharmacology/Action field
	Usual Dosages	Add repeat x 1
Morphine	Indications	Amend >6 to ≥6
	Contra-Indications	Amend Head Injury to Brain Injury. Move Acute respiratory distress to the Additional Information Field
Nitrous Oxide 50% & Oxygen 50% (Entonox®)	Additional Information	Add "APs may use discretion with minor chest injury"
Ondansetron	Side Effects	Hiccough
Oxygen	Presentation	Add CD Cylinder - white
Paracetamol	Indications	Remove "between" amend CPG to reflect this
Salbutamol	Indications	Remove Anaphylaxis and Acute Asthma
	Usual Dosages	Amend 15mins to 5mins and change CPG
	Additional Information	APs may repeat salbutamol x 3 (change CPG)
Sodium Bicarbonate Injection BP	Indications	Add Arrhythmias "and" or seizures
Sodium Chloride 0.9%	Administration	Add (IO) and "Paramedic maintain infusion once commenced"
Tenecteplase Powder for Injection	Contra-indications	Add pregnancy "and" within one week post partum
	Usual Dosages	Amend typo "> 90"

4. Paediatric Age Calculation Formula

Mr. Brian Power introduced the Paediatric Age Calculation formula chart comparing the calculation methods of Age x 2 + 8 kg and Age x 3 + 4 kg. In general it was indicated that the latter results in slightly less (Dose?) in lower age categories and higher in the older ages.

Dr. David Janes gave his support to the amending of the paediatric age calculation formula, however was concerned that the calculation of Age x 3 + 7 kg was now thought as being best practice. Prof. Gerard Bury suggested that a report by Sloan which is available from the Dept of Health and Children be reviewed before progressing. The Chair asked that Dr. David Janes and Prof. Gerard Bury research this matter and decide on the most appropriate to proceed with.

Proposal: that Dr. David Janes and Prof. Gerard Bury research and choose a suitable Paediatric Weight Calculation Formula.

Proposer Dr Mark Doyle

Seconded Dr David Janes

Carried without dissent

5. Compression Only CPR (for first two minutes in unwitnessed arrest)

Mr Brian Power discussed various papers with the group that show benefits in the use of Compression only CPR for the first two minutes in unwitnessed arrest. Mr Power suggested that there is now an opportunity to amend the CPG to go from 2 minutes of standard CPR and replace it with 2 minutes of compression only CPR in the case of an unwitnessed arrest.

Dr David Janes indicated that although the Physiological theory was correct there is a lack of evidence to justify moving from the current procedure. He also indicated concerns in the case of airway issues where patients may benefit from ventilations.

Prof Gerard Bury informed the group that the ERC and the AHF have conflicting views on the benefits on moving to compression only CPR.

The Chair suggested that the developments are monitored but no change is made as yet.

6. External Review of CPG's

The Chair announced to the group that the external review of the new CPG's is now complete and the external review panel (Mr. Cathal O'Donnell, Martin O'Reilly, and Brian Power) have reported back their findings. The Chair gave examples to the group of some of the recommendations made, all of which were agreed to be reasonable. The main issue raised by the Chair was the inclusion of "Treat and Discharge" on various CPG's. Currently no context or structure has been established for treat and discharge which raised concern as to how they should be included in the CPGs.

The Chair indicated that if certain responders CPGs are followed exactly there is a risk that ambulances may be called to cases which do not necessarily need the assistance of the emergency services - inclusion of treat and discharge will place an onus on companies to develop their own organisational protocols. This would apply to non practitioner levels only. The Chair suggested that a symbol for Treat and Discharge should be used and included in the explanatory notes of the CPGs

It was agreed that a text box with "follow organisation protocols for minor injuries" be included on the CPG.

Mr. Sean Creamer raised a concern that a Responder can technically treat and discharge but a practitioner must transport. Prof. Gerard Bury suggested that the duty of care between voluntary and professionals is different and should be defined as so.

Mr. Brian Power informed the group the there are only 3 – 4 CPGs where treat and discharge is present and that at Responder level the type and graveness of injuries encountered would be of much lesser severity than those being dealt with by practitioners. The element of treat and discharge would regularise vehicles being held up unnecessarily over minor injuries.

A discussion ensued regarding the lead time of "treat and discharge" being finalised. It was agreed that the Treat and Discharge system be viewed as a priority for the next MAG.

Proposal: That the Medical Advisory Group approve the new 3rd Edition CPGs

Proposer:

Seconded:

Carried Without Dissent

7. AOB

7.1 For inclusion in the next MAG business.

Mr. Declan Lonergan asked that the issue of Pandemics and in particular the ability of an advanced Paramedic to administer antivirals be discussed at the next MAG meeting.

Mr. Macartan Hughes asked that issues that were due for further discussion be prioritised namely, the development of an Acuity Scale, the use of LM CO₂ detectors and the completion of a CPAP CPG.

Dr David Janes asked that any developments in the standardisation of Methods of Notification for decisions from the MAG be placed on the agenda. In addition Dr. Janes asked that progress in the Pre Arrival Instruction be reviewed. The Chair notified the group that a linguistic specialist is currently reviewing the Pre Arrival Instructions.

7.2 Asystole Algorithm

Mr Lawrence Kenna requested clarification on cease resuscitation after 20 mins in the case of VF correct going into asystole.

It was agreed that once the CPGs were followed, which included 20mins of resuscitation of patients in asystole, resuscitation could be ceased by Paramedics and Advanced Paramedics.

7.3 Chairs Message

The Chair thanked all MAG members for their input to the MAG meetings over the duration of the current council.



Minutes MAG meeting December 11th 2008, PHECC office Naas

Present:

Mr. Cathal O'Donnell, Chair
Mr. Martin O'Reilly
Dr. Zelig Gaffney
Mr. Declan Lonergan
Mr. Mark Doyle
Mr. Brendan Whelan
Mr. Frank O'Malley
Mr. Michael Garry
Mr. Vincent O'Connor
Mr. Macartan Hughes
Mr. Stephen Cusack
Dr. David Janes
Mr. Connor Egleston

In Attendance:

Dr. Geoff King
Mr. Brian Power
Mr. Ricky Ellis
Ms. Deirdre McHugh

Apologies:

Ms. Valerie Small
Mr. Tom Mooney
Mr. John O'Donnell
Mr. Fergal Hickey

1. Chair's business

The Chair acknowledged the work of the previous MAG under the leadership of the previous Chair Mr. Mark Doyle

1.1 Membership

The Director gave details of the current make up of the MAG detailing that there are still a number of vacancies awaiting nominations from Dublin Fire Brigade and the Health Services Executive.

The practicalities of joining the European Resuscitation Council were discussed. The Director indicated that there is a requirement for representation from fields such as Intensive Care and Cardiology which is currently lacking in the fields of expertise represented on MAG.

Mr. Mark Doyle queried the need for an Irish Resuscitation Council as a prerequisite of joining ERC and the extent of how the Irish Heart Foundation could be involved with such a move. As ACLS is taught to thousands of hospital staff not ERC ALS, changing this would be a major undertaking.

Dr. David Janes questioned to what extent an “Irish Resuscitation Council” would have to follow the ERC guidelines and that maybe a compromise could be gained by still using the AHA guidelines if desired.

Resolution

That PHECC explores the feasibility and implications of joining the European Resuscitation Council

Proposer: Mr. Mark Doyle Seconded: Dr. David Janes

1.2 The Chair invited nominations for the role of Vice Chair of MAG

1.3 **Meetings**

Resolution

Future MAG meetings will be held on Tuesdays and Thursdays on an alternating basis and some meetings to be held outside of Naas.

Proposer: Mr. Stephen Cusack Seconded: Mr. Mark Doyle

1.4 **Suggestions for MAG deliberation**

The Chair asked for input as to relevant items for inclusion for future agendas. The Summary of Sentinel Achievements and Recommended Priorities were distributed to the attendees.

Dr. David Janes asked that the issue of maintenance of the 2nd edition CPGs be kept in mind prior to the implementation of the 3rd Edition CPGs.

1.5 **Treat and Discharge by Advanced Paramedics**

Mr. Brian Power indicated that he is currently gathering data on Treat and Discharge by Advanced Paramedics. A survey will be sent to Advanced Paramedics to assess the safety and efficacy of treat and discharge. Mr. Power stated that the gold standard against which the

treat and discharge decisions of APs would be measured was the Consultant in Emergency Medicine's opinion of the selected cases.

As the survey would help to inform decisions on future treat and discharge CPGs, Mr Power requested that all the Consultants in Emergency Medicine on MAG would give the study its full support. Mr O'Donnell urged all to get involved.

1.6 Ambulance service airway management

The Chair informed the members of a paper issued by JRCALC, "A Critical Reassessment of Ambulance Service Airway Management in Pre-Hospital Care" and suggested that this should be discussed at a future meeting.

Mr. Mark Doyle suggested standards of patient care be discussed in particular the notion of care bundles and treating the patient from the view point of what they require rather what the practitioner can do.

The development of care bundles was discussed at length, including whether it was within PHECCs remit to set these standards.

The Director indicated that PHECC can prepare a concept only sample in conjunction with Mr. Mark Doyle and present it at the next MAG meeting.

1.7 Critical Skills Appraisal Workshop

The Chair distributed a letter of invitation to a Critical Skills Appraisal workshop which will be held in Limerick on Feb 26th - 27th 2009. There are 20 places available and MAG members are welcome to attend if interested. The aim of this workshop is to improve skills for developing evidence based CPGs and to develop a clinical library for CPG development. All interested parties were asked to contact the Chair. The closing date for receipt of applications is Friday 19th December.

2.0 Meeting Report – 6th May 2008

2.1 Communication

Dr. David Janes asked that the issue of how MAG communicate its decisions to the concerned parties be discussed. The Director indicated that PHECC were open to views on what the channels of information should be.

2.2 Paediatric Weight Calculation

Dr. David Janes also raised the issue of Paediatric Weight Calculation Formulae. He presented 3 research papers and suggested that MAG adopt the formula of $\text{Age} \times 3 + 7$ as he understood it to be more suitable formulae in respect of the growing weight of Ireland's child population. Dr. Conor Egleston questioned the evidence base of the papers, and the validity of the necessity to change the currently thought formula.

The Chair indicated that Advanced Life Support Group should be the ones to make this decision as it may lead to confusion having two recommended formulae

Resolution

That the $\text{Age} \times 3 + 7$ formulae and papers to sent to ALSG for their comment.

Proposer: Dr. David Janes Seconded: Mr. Mark Doyle

Resolution

That the minutes of the MAG meeting held on May 6th 2008 be approved

Proposed: Mr. Peter O'Connor Seconded: Mr. Macartan Hughes

3. 3rd Edition CPGs completed

- 250 CPGs completed
- Comparisons with 2nd Edition
- Knowledge, skills and medications implementation

Pain relief was discussed, in particular the requirements to exceed 10 mg morphine IV for long transport times: a system of medical on line advice requires development to address this and other pre-hospital issues.

The basis of the CPGs is that no previous interventions have been made. Practitioner must take conscience of treatment/medications administered prior to their arrival on site. This is to be communicated to the training institutions.

Resolution

That "The basis of the CPGs is that no previous interventions have been initiated prior to arrival of Practitioner or Responder" be included in the introduction of the 3rd Edition CPGs

Proposed: Mr. Martin O'Reilly Seconded: Mr. Macartan Hughes

4. Oxygen Therapy

Mr. Brian Power gave an overview of the British Thoracic Association Oxygen guidelines which was included for review in the meeting papers.

A discussion ensued regarding Oxygen Therapy for patients with COPD. Mr. Mark Doyle expressed a concern that the adoption of the British Thoracic Association Oxygen guidelines may lead to those who need Oxygen being denied it through fear/assumption that the patient has COPD.

The COPD Card and venturi mask was discussed. Mr. Mark Doyle said it should be encouraged that everyone with COPD has this card. The group indicated that it should not be necessary to have pulse oximetry available when giving oxygen

There was general agreement to maintain the current O₂ saturation of >97% and not change to the BTS guideline of 94% to 98%.

Resolution

The Chair works with Mr. Brian Power on appropriate wording of O₂ therapy for those with established COPD

Proposed: Mr. Mark Doyle Seconded: Mr. Stephen Cusack

5. Publications (to be tabled)

The following publications were circulated for information:

- The 2008 PHECC View
- Statutory Registration and Pre-Hospital Emergency Care Practitioners

6. A.O.B.

Dr. David Janes acknowledged the contribution of PHECC to the development of Irish Pre-Hospital Services and expressed a wish that the work will continue in light of the plans for PHECC's proposed amalgamation.

The Director gave an account of the current status of the aforementioned amalgamation

The next MAG meeting will be held on February 3rd in the PHECC office at 10.30

7 Tabled documents

The PHECC View and Statutory Registration publications were distributed for information.

8 A.O.B

- 8.1 Dr. David Janes asked that the concept of online medical advice for Practitioners be scheduled for a future MAG meeting. The Chair informed the group that Limerick currently offers 24 hour online advice for Advanced Paramedics; he indicated that thus far take-up has been low.
- 8.2 Dr. David Janes asked for clarification as to the methods of communicating changes in CPGs to Practitioners. Mr. Brian Power gave an account of the PHECC CPG webpage and email mail shots.
- 8.3 Mr. Macartan Hughes enquired as to whether the former members of the Medical Advisory Group had been formally written to yet. The Director said this would be done when current membership is finalised.
- 8.4 Prof. Gerry Bury expressed a concern that PHECC registered Practitioners use a different anaphylaxis CPG than those used by GPs (as per the R.C.P.I. guidelines). The principle differences between both are the inclusion of Chlorpheniramine and Hydrocortisone in the RCPI guidelines. Brian Power informed the meeting that Hydrocortisone is on the current medicinal products schedule, however Chlorpheniramine is not. Brian Power was requested to update the PHECC CPG to match the RCPI guideline where possible.
- 8.5 A discussion was held regarding difficulties that have occurred regarding procedures relating to deceased patients, particularly where there has been Garda involvement. The Chair asked that the Coroners Association and Religious Institutions be contacted with a view to gaining advice. It was agreed that Dr. David Janes, Mr. Martin O'Reilly and Brian Power would form a sub group to look at this issue.
- 8.6 A discussion took place on the absence of a specific CPG for COPD. It was felt that the issue was not adequately covered on the 'Inadequate Respirations' CPG. Brian Power was requested to draft a new CPG for this issue.

The Chair thanked the group for their attendance

The next MAG meeting will be held on March 26th in the PHECC office at 10.30am

Chair: _____

Date: _____

Meeting Report of Medical Advisory Group Meeting held on the 31st January, 2007 Boardroom, PHECC Offices, Abbey Moat House, Abbey St, Naas, Co Kildare.

Present: Mags Bourke (Vice-Chair)
Gerard Bury
Cathal O'Donnell
Macartan Hughes
David Janes
Laurence Kenna
Vincent O'Connor
John O'Donnell
Danny O'Regan
Michael Seaman

Apologies: Richard Lynch
Fergus McCarron
Fergal Hickey
Julie Woods
Stephen Cusack
Conor Eggleston
Paul Robinson
Declan Lonergan
Geoff Keye
David Hennelly
Brendan Whelan
Martin O'Reilly
Sean Creamer

In Attendance: Brian Power
Jacqueline Egan
Geoff King
Sharon Gallagher

1. **Chairman's Business**
No matters discussed.
2. **Meeting Report and matters arising**
 - 2.1 **Meeting Report**

Resolution: That the meeting Report of the Medical Advisory Group 28th November 2006 be agreed.

Moved: Dr David Janes
Carried without dissent

Seconded: Mr Lawrence Kenna

2.2 Matters arising

The Vice Chair informed members that Mr Martin Gallagher, Council member had recently passed away after a brief tragic illness. The group expressed their sympathy to his widow Rita and family.

3. CPG-As (ILCOR) updates

Mr Brian Power distributed CPG-As 5, 6, 7 & 51 and he outlined that these were an updated version of those distributed in the meeting papers.

The following were agreed:

CPG-A 5 Adult VF and Pulseless VT

Emphasise 2 minute CPR before first shock, for unwitnessed arrest.

In text box “go to CPG-A” insert word “appropriate” after “to”.

Extend advanced airway management brackets to incorporate maximum time frame.

Bold all treatable causes in information box.

Replace text box “analyse/verify rhythm” with text “rhythm check” and an *.

Insert note * “pulse check after 2 minutes of CPR if potentially perfusing rhythm”. Insert an advice box “change defibrillator to manual mode”.

Interim Cardiac arrest CPG-3a to be issued in parallel with the CPG-A 5.

CPG-A 6 Adult PEA

Replace text in “analyse” text box to read “rhythm check” and include an asterix “*” - note to be inserted at bottom of CPG to read * “pulse check after 2 minutes of CPR if potentially perfusing rhythm”.

After “1st rhythm check” insert “PEA” decision diamond. “If no go to appropriate CPG-A”. “If yes go to 2 minutes of CPR”.

Change bradycardia to “rate<60” in decision diamond, if no go to “if persistent PEA continue CPR” if yes give “atropine” in parallel with 2 mins of CPR.

Extend advanced airway management bracket to include maximum time frame.

Bold all treatable causes in information box.

CPG-A 7 Asystole

Changes to “rhythm” section as per previous 2 CPG-As.

In consider “ceasing resuscitation” box insert “only” before “if patient is not”.

Reword final box to read “if persistent Asystole for <20mins consider ceasing resuscitation.
Extend advanced airway management brackets to incorporate maximum timeframe.

It was agreed that MAG members need to be contacted to get consensus on the CPR treatment timeframe standard for unwitnessed Asystolic arrest.

To be agreed “on scene time spent resuscitating Asystolic arrests – consider extending to 20 mins” – all MAG members to be consulted regarding above.

CPG-A 51

Paediatric VF and Pulseless VT.

Typo – “rescuer”.

Change text box on top right hand corner “Immediate IO access if no IV in situ” to “if no IV immediately accessible”.

Change “go to CPG-A” to “go to appropriate CPG-A”.

Resolution: That CPG-As 5, 6, 7 & 51 receive interim approval subject to the above amendments.

Moved: Macartan Hughes
Carried without dissent

Seconded: Vincent O’Connor

4. CPG Review

4.1 Delphi Process

The following were agreed:

CPG 13e Glycaemic Emergency - Paediatric Level P & AP

Replace first text box “altered level of consciousness” with abnormal blood glucose level”.

In left arm <3 mmol/L “consider buccal glucose gel”.

For adult reduce from 4 mmol/L to 3 mmol/L.

Right arm change 10 mmol/L to 20 mmol/L.

Delete text box convert mmol/L to mg.

CPG 13e Glycaemic Emergency - Paediatric Level 4 (EMT)

Replace “altered level of consciousness” with “Abnormal Blood glucose level”. Insert “A or V” decision diamond.

In medication text box change first section to read “Consider glucose gel buccal or sweet drink” if A or V.

For P or U give glucagon.

CPG 13e Glycaemic Emergency - Paediatric Level 3 (EFR)

It was decided there was no requirement for this CPG for level 3.

CPG Acute Coronary Syndrome – Level 4 (EMT)

Change wording in initial box from “chest pain/suspected heart attack to “cardiac chest pain”.

Delete text box on right hand side relating to morphine IM.

GTN could be given before transport.

Important to emphasise time is critical to get to hospital in case of MI.

It was agreed to move ambulance/transport icon in parallel with activities to avoid delays.

Insert small text box beside ambulance icon to read “commence transport to definitive care ASAP”.

It was agreed that EMTs should not administer Clopidogrel, but to explore the appropriateness of paramedics administering it.

CPG Acute Coronary Syndrome – Level 1, 2 & 3

Change text in first text box to read “cardiac chest pain”.

Delete “EFR” diamond.

Delete “reassess” after monitor vital signs.

CPG Paediatric Pain management Level 4-6

Concerns with IM morphine administered at P & EMT level were expressed.

Insert “appropriate” prior to registered medical practitioner’s instructions.

The term “appropriate” medical oversight will be contextualised in new edition of Clinical Handbook.

Delete tetracaine from CPG.

Reverse left and right limb to reflect lower scale levels on left.

Reduce initial morphine dose to 0.02 mg/kg IV.

Change morphine dose to read - “repeat morphine at not <2min intervals if indicated. Max 0.1 mg/kg”.

Include oromorph with appropriate doses as in alternative to IV morphine.

It was agreed to edit the CPG with the above amendments and forward to all MAG members for response through a re-delphi process.

Note The administration of IM morphine for Paediatric patients by EMTs and Paramedics was supported by Geoff King and Cathal O’Donnell but dissented by Mags Bourke and John O’Donnell.
Insert a note “decisions to give analgesia must be based on clinical assessment and not directly on linear scale”.

This CPG will be presented back to MAG following re-Delphi.

CPG 13b – Pain management adult

Remove left limb of algorithm.

A clinical assessment on judgement of pain should be used with pain score scales.

Pain \geq 5 consider morphine 2 mg IV. Repeat at 2 minute interval to a max of 10 mg.

Combine pain levels 3-5 and delete pain levels 1-2 for drug administration.

It was agreed to send this CPG (as previous one) to MAG members for re-delphi and take back to MAG at next meeting for approval.

CPG – A4 Anaphylaxis Adult Level EMT, P and AP and CPG-A 55 Anaphylaxis Paediatric

Time did not permit discussion on these CPGs and were therefore deferred to next meeting.

Resolution: That Delphi 6 CPGs on Paediatric Glycaemic emergencies and ACS receive interim approval subject to the above amendments.

Moved: Cathal O'Donnell **Seconded:** Vincent O'Connor
Carried without dissent

4.2 Treat and Discharge

It was agreed to defer this item to the next MAG meeting.

4.3. Paediatric Age Range

The correspondence from Dr Ciara Martin, The Adelaide and Meath Hospital incorporating the National Children's Hospital, Tallaght was distributed in the meeting papers. It was agreed that age range for paediatric would be classed as follows:

- Paediatric up to 14th birthday i.e. <14 yrs for Paediatric drug administration.

Resolution: That the age range for paediatrics in PHECC Clinical Practice Guidelines is <14 years with the exception of Paediatric defibrillation which remains at <8 years. The age for paediatric intubation will be discussed at a future MAG meeting.

Moved: David Janes **Seconded:** John O'Donnell
Carried without dissent

5. Directors Update

The Director briefed members on the following items:

- Mission / View poster was distributed.
- Council approved the following standards in November and December 2006 CFR, EFR, EMT and P levels.
- Funding for ePCR from HSE for National implementation.
- Funding provided to NUI Galway to establish an out of hospital cardiac arrest register and Dr Peter Wright to direct this project.
- PHECC Register – invitation to join the Register is being offered to the Private, Voluntary and Auxiliary organisations.
- Training Institutions need to be re-accredited by 1st April 2007.
- Funding provided to UCD for Medical oversight project.
- Research proposal for UCL to establish a national Pre-Hospital Emergency Care Research “Clearing House”.

6. AOB

PHECC to come back to MAG with evidence on LMAs and LTs. Cathal O’Donnell agreed to forward appropriate literature to the Director and Dr Mags Bourke on same.

The Vice-Chair requested members to submit questions on MCQs and Short answers (especially in area of AP) to Pauline Dempsey, Project Officer. It was outlined that PHECC have guidelines drafted to aid question development and this will be sent to all members for guidance on same.

It was also noted by the Director that Mr Kevin Flannery, Ambulance Project Officer, HSE West has been seconded on a part-time basis to PHECC to aid in the development of evidence for the CPGs.

Brian Power requested members to review the Batch 6 CPGs (in the January meeting papers) and forward comments to him prior to next MAG meeting ASAP.

The next MAG meeting is scheduled for Tuesday 27th February at 10:30am in the PHECC Office.

Signed:

Date:

Dr Mags Bourke
Vice - Chair

Meeting Report of Medical Advisory Group Meeting held on the 27th February, 2007 Boardroom, PHECC Offices, Abbey Moat House, Abbey St, Naas, Co Kildare.

Present: Mags Bourke (Vice-Chair)
John Burton
Cathal O'Donnell
Macartan Hughes
David Janes
Laurence Kenna
Geoff Keye
Declan Lonergan
Vincent O'Connor
John O'Donnell
Danny O'Regan
Fergus McCarron
Brendan Whelan
Martin O'Reilly

Apologies: Fergal Hickey
Julie Woods
Stephen Cusack
Conor Egleston
Paul Robinson
Sean Creamer
Michael Seaman

In Attendance: Brian Power
Jacqueline Egan
Kevin Flannery
Geoff King
Sharon Gallagher

1. Chairman's Business

No matters discussed.

2. Meeting Report and matters arising

2.1 Meeting Report

The following amendments were agreed:

Page 3 - error in first sentence – “if persistent Asystole for >20 mins” not “<20 mins”.

Page 4 - last paragraph entitled 'NOTE' at bottom of page – Delete first sentence of paragraph and replace with sentence “concerns with IM Morphine were raised”.

Page 6 Section 6 - 'AOB' – end of first sentence to read “LMAs, LTs and Combitubes”.

Resolution: That the meeting Report of the Medical Advisory Group 31st January 2007 be agreed with the above amendments.

Moved: Dr David Janes **Seconded:** Mr Brendan Whelan
Carried without dissent

2.2 Matters arising

Martin O'Reilly queried note on page 2, section 3 – 'Pulse check' - and requested correspondence from PHECC to outline formally the change outlined. Brian Power agreed to follow up with DFB/RCSI.

3. CPG Review

3.0 Hypoglycaemia Treat and Discharge Protocol.

Mr Cathal O'Donnell outlined the principles of the Protocol, Advice Sheet and Discharge Letter as distributed in the papers.

The inclusion of the protocol on the PCR was raised and it was agreed that practitioners need to demonstrate that they have endeavoured to assess the capacity of the patient.

David Janes agreed to circulate a training presentation as used in UCD/NATS in the instruction of the concept of “informed consent” to members from level P upwards.

Discussion ensued on corresponding with the patient's GP and as to whether notification should be given to patient or if it should be forwarded through the paramedic GP with a copy of the PCR.

It was agreed to amend point 1 on the Protocol
“History of IDDM” instead of “or NIDDM”.

Delete last sentence in 'Introduction' of protocol - “A recent review of the literature concluded that out of hospital treatment for hypoglycaemia was safe for approximately 90% of patients”.

Advice sheet

Amend point 4 on Discharge Advice Sheet.

To include “If you go to sleep you should be woken by a responsible adult every 2 hours for 12 hours”.

Also edit last paragraph on advice sheet to read “if you have notified us of your GP he/she will receive written notification by post that you have been treated by us, to allow him or her to continue to provide the best possible treatment to you.

GP Letter

It was agreed to include “date of birth” on the treat & discharge letter.

Jacqueline Egan outlined that electronic messaging functionality could be incorporated into the ePCR.

It was agreed to bring the Hypoglycaemic Treat and Discharge Protocol back to MAG for Paramedics and Advanced Paramedics in a CPG format with a methodology that would be most beneficial to GPs and Emergency Departments.

PHECC will return to MAG as appropriate with a list of suggestions for follow up and would preserve in principle the protocol, letter and advice sheet developed by Cathal O'Donnell with the concept of developing other relevant treat and discharge protocols.

It was also agreed that treat and discharge would be included on the next edition of the PCR.

All members present supported the above principle of treat and discharge protocol.

Batch 7 CPGs

Pregnancy CPGs 22, 21, 20

It was agreed to that anti partum and post partum remain separate, but combine the others "under 26 weeks".

It was agreed to include "ask/check for history of multiple births".

Obstetricians and midwives to be consulted for further development on CPG content.

Discussion ensued on urinary catheterisation, and it was agreed for the interim to leave it in the CPG as "consider urinary catheterisation".

Include IV access on right arm of CPG.

CPG 19 Post resuscitation Care - Adult EMT, P and AP.

It was agreed to remove the following: naso-gastric tube, Monitor Hyperthermia, before the CPG goes through the Delphi process.

Insert "if required" with repeat Atropine.

CPG 19 Post resuscitation Care – Adult CFR OFA and EFR

It was agreed to remove "monitor hyperthermia".

3.2 Asystole CPG feedback

The feedback from the Asystole CPG questionnaire was circulated and following discussion it was agreed that the time spent resuscitating a patient with an unwitnessed Asystolic arrest should be 20 minutes.

Resolution: That the time spent resuscitating an unwitnessed Asystolic arrest is 20 mins.

Moved: Fergus McCarron
Carrie without dissent

Seconded: John Burton

3.3.0 Delphi Process

3.3.1 Delphi 6

CPG – A4 Anaphylaxis Adult

Divide CPG into “*mild, moderate and severe*” and define “severe as respiratory and/or haemodynamic compromise”.

Include O₂ in moderate limb; bring IV access higher on moderate limb. The Autoinjection for use by EMTs is 300 micrograms. The autoinjection for use only by EMTs if prescribed for specific patient.

Mild limb – include urticaria in definition of mild anaphylaxis.

CPG – A4 Anaphylaxis Paediatric

Apply the same changes as per Adult CPG A4 outlined above.

Resolution: That Delphi 6 CPGs be approved with the above amendments.

Moved: Declan Lonergan
Carried Without dissent

Seconded: Macartan Hughes

3.3.2 Delphi 6a-

CPG 13b Pain management – Adult

In Morphine information box include “if IV not accessible morphine 10 mg IM.” And at bottom of info box include “No IM for cardiac chest pain”.

Include the word “or” between Paracetamol and Ibuprofen text boxes, i.e. to read “and or”.

In “go to” box at bottom of CPG change the word “*original*” to “*originating*”.

Members present expressed concern with EMTs and Paramedics administering IM Morphine under registered medical practitioners instructions. It was pointed out that this was the current legal situation, however, there is an issue regarding the possession and storage of morphine. It was agreed that practitioners, responding in inaccessible areas with formal Medical Oversight would be supported to administer Morphine IM.

CPG 13b Pain management – Paediatric (<14)

Include the word “or” between Paracetamol and Ibuprofen text boxes, i.e. to read and or.

In “go to” box at bottom of CPG change the word “*original*” to “*originating*”.

Following discussion it was agreed that 0.05 mg/kg up to max of 0.15 mg/kg IV should be administered. It was agreed that oral morphine dose is double the IV dose.

At bottom of text box include “*IV morphine only*”.

The issue of IM morphine administered by EMTs and Paramedics was agreed as per adult CPG.

Resolution: That Delphi 6a CPGs be approved with the above amendments.

Moved: Declan Lonergan
Carried without dissent

Seconded: David Janes

3.3.3 Delphi 7

CPG 6a Burns Management Adult EMT, P and AP

Change text box “superficial injury” to “superficial injury excluding face, hands feet, flexion points or perineum”.

Under the airway management text box – insert “Consider humidified O₂” and another text box underneath “Go to airway management CPG”.

Edit both “cooling” text box to read “Commence local cooling of area, 15 mins cooling optimal.”

Delete section “body surface area burn – on right arm of CPG.

Under this area include “IV access” and a further text box “if time from injury to ED >1hr commence IV fluids”.

Edit the discharge text box to read “If appropriate history and $\leq 1\%$ of surface burn area – discharge into care of competent person”.

If “no” insert arrow to transport icon.

Table changes at next meeting.

CPG 6a Burns Management Adult OFA EFR

To reflect changes agreed in Paramedic and Advanced Paramedic levels and table at next meeting.

Spinal Immobilisation – Adult CPG 7a P & AP

The current CPG 7a in relation to neutral head position to be inserted.

Use the “Canadian C Spine rule” as starting point of CPG.

Remove CUPS text box and insert new patient category.

Edit text box to “Load onto Spinal board to include “/ vacuum mattress”.

It was agreed to restructure and re-table the revised CPG at the next MAG. Brian Power and Cathal O’Donnell agreed to liaise on same.

Spinal Immobilisation – Adult CPG 7a OFA, EFR and EMT

Insert CPG 7a as per previous CPG – head return to neutral position.

CPG 7a will be developed separately for EMT resulting in a separate CPG for OFA and EFR.

Changes in reference to vacuum mattress as agreed with P & AP levels.

Limb Fractures Adult – CPG 8a P and AP

Change first text box to read “isolated limb fracture” not “suspected limb fracture”.

Delete CUPS box and left limb of CPG

Insert ambulance in parallel to main algorithm as this will facilitate treatment en route.

Change fracture text box at bottom of CPG to read “Fracture mid shaft of femur”.

Limb Fractures Adult – CPG 8a OFA, EFR and EMT

Change first text box to read “isolated limb fracture” not “suspected limb fracture”.

Delete CUPS box and right limb of CPG except section below “continue manual stabilisation”.

Change text box at bottom left handside to read “apply appropriate nontraction splinting device”.

The CPG will be split for EMT and OFA & EFR.

Altered level of consciousness – Adult CPG 11a

Delete first section of CPG i.e. from “simple faint” to adequate ventilations.

Move SAMPLE box higher in limb

Delete AVPU box prior to transport icon.

Symptomatic Bradycardia Adult – CPG A8 EMT, P and AP

Edit first text box to read “symptomatic bradycardia”

Delete text box HR <50 and the entire right limb of this text box i.e. “ECG and SpO2” monitoring “IV access”

Delete text box at bottom of algorithm “symptomatic bradycardia”

It was agreed that a cardiology expert opinion be sought on the use of atropine for Type II 2nd degree and 3rd degree heart block. Kevin Flannery also agreed to research current data and return to MAG.

Resolution: That Delphi 7 CPGs 7a for OFA, EFR & EMT, 8a all levels, 11a and A8 be approved with the above amendments.

Moved: Brendan Whelan
Carried without dissent

Seconded: David Janes

5. AOB

The Director advised that a major communication exercise with the Emergency Departments will be undertaken on publication of the Edition 3 CPGs.

The next MAG meeting is scheduled for Tuesday 27th March at 10:30am in the PHECC Office.

Signed:

Date:

Dr Mags Bourke
Vice - Chair

Meeting Report of Medical Advisory Group Meeting held on the 10th April, 2007
Boardroom, PHECC Offices, Abbey Moat House, Abbey St, Naas, Co Kildare.

Present: Mark Doyle
John Burton
Macartan Hughes
David Janes
Laurence Kenna
Declan Lonergan
Vincent O'Connor
Cathal O'Donnell
Martin O'Reilly

Apologies: Fergal Hickey
Julie Woods
Paul Robinson
Sean Creamer
Michael Seaman
Kevin Flannery
Brendan Whelan
Richard Lynch
Fergus McCarron

In Attendance: Brian Power
Sharon Gallagher

1. Chairman's Business

Mark Doyle resumed the role of chair.

2. Meeting Report and matters arising

2.1 Meeting Report

The following issues were discussed:

Following discussion it was agreed that the term "Spinal board" should be changed on all CPGs to "long board".

Page 4 – CPG 13b Pain management Adult and Paediatric – discussion ensued on the administration of IM Morphine as per previous MAG meeting and it was agreed that the February meeting report did not reflect the group's agreement on administration of Morphine and the issue needed to be clarified as below:

"The use of IM Morphine at Paramedic and EMT level for specific providers may be approved by PHECC upon application to the Director".

It was agreed to amend CPGs on Pain management to reflect above and that an asterisk need to be inserted on the CPG referring to the particular note on the administration of Morphine.

Resolution: That the meeting Report of the Medical Advisory Group 31st February 2007 be agreed with the above amendments.

Moved: Dr David Janes
Carried without dissent

Seconded: Mr Macartan Hughes

3. **CPG Review**

3.1 **CPG 6a Burns Management EMT, P and AP**

The above CPG was retabled with the revisions as requested at the previous meeting.

It was agreed to delete direct arrow from the “go to CPG 13b” text box to the “monitor body temperature box” and to replace with two arrows from the “go to CPG 13b” text box, one directed to “appropriate history and burn area ≤1%” and the second going to “TBSA burn > 10%” box”.

It was agreed that generic names should not be used and hence to change “burns Jel” to small “j” as follows “burns jel” and delete “glad wrap”.

It was agreed to insert a direct arrow from text box “superficial injury “excluding FHFFP” to “commence local cooling of burn area”

“Facial and/or inhalation injury” to emerge directly from “cease contact with heat source” box.

Delete arrow from text box “Inhalation injury” to text box “commence local cooling of burn area”.....

CPG 6a Burns Management (OFA and EFR Levels)

It was agreed to change inhalation injury as per outlined at EMT, P and AP levels.

Resolution: That both the CPG 6a Burns Management – Adult (EMT, P & AP levels and OFA & EFR Levels) be approved.

Moved: Vincent O’Connor
Carrie without dissent

Seconded: Martin O’Reilly

3.2 **CPG 7a Spinal Immobilisation (P and AP levels)**

The above CPG was re-tabled as requested at previous meeting. Two algorithms for Spinal Immobilisation were presented, firstly the Canadian C Spine Rule and secondly the Nexus Rule. It was agreed the Canadian C Spine Rule was best evidenced based but needed to be adapted for use pre-hospital.

The following adaptations were included;

- In diamond text box containing “dangerous mechanisms or penetrating trauma” insert “or distracting injury”.

- In the Red information box it was agreed to insert the word “include” in the heading as follows “Dangerous mechanisms include”. It was also agreed to insert “Pedestrian V vehicle” in this list.

Replace “regardless of pain” with “pain free” in the text box “patient voluntarily able to actively rotate neck 45°”

Insert extra diamond containing “patient can walk pain free”, if “yes” immobilisation not indicated.

In “Low risk factors box” remove line “ambulatory at any time at scene”. Insert decision diamond after “immobilisation not indicated” in relation to minor trauma. If yes “consider treat & discharge”.

Cathal O’Donnell congratulated Brian Power on the excellent job in translating the “Canadian C-spine rule” (as it is a little cumbersome), into an easily followed algorithm.

Resolution: That CPG 7a Spinal Immobilisation Adult (P and AP levels) be agreed with the above amendments.

Moved: Cathal O’Donnell
Carrie without dissent

Seconded: Macartan Hughes

3.3 **Delphi Process**

Mr Brian Power advised members of the inclusion of a percentage statistic in the introductory page of all Delphis to help summarise “agrees” and “disagrees”.

3.3.1 **Delphi 8**

CPG 4a – Primary Survey Medical Adult (OFA & EFR) and Primary Survey Trauma

It was agreed to combine Medical and Trauma at these levels.

Replace text in box “give 2 initial Rescue breaths....” with “Commence CPR”.

Include Pulse and respiratory assessment rate and “control external haemorrhage”.

Insert an advisory box with Normal pulse and respiratory rates.

Include E – “Consider need to expose and examine patient”.

It was agreed that “jaw thrust” should be inserted for EFR use only and not OFA.

CPG 4b – Primary Survey Medical Paediatric and Primary Survey Trauma Paediatric (EFR)

It was agreed to combine Primary Survey Medical and Trauma for Paediatric as per outlined in Adult above.

Insert a table with normal Paediatric pulse and respiratory rates.
It was agreed to change the age range on title to ≤ 13 years.
Include control external haemorrhage.
Include pulse and respiratory assessment
Include E – “Consider need to expose and examine patient”.
It was agreed that “jaw thrust” should be included for EFR use only and not OFA.

CPG 10 Acute Coronary Syndrome

Discussion ensued on Thrombolysis and call/pain to needle times and distance to ED. It was decided that the CPG must be consistent with the recommendations of the Sudden Cardiac Death Task Force Report i.e. PCI available within 60 mins of the patient contacting the Health Services. Also to remove time frame to ED and thrombolise patient at earliest time.
It was agreed to move the IV access text box to above chest pain box.
It was agreed to group the contraindications systematically.
Dose of Heparin and the sequence of administration of Heparin and tenecteplase to be agreed with the Chair, Mr Mark Doyle.

CPG-A 11 Adult Seizures (OFA and EFR)

It was agreed to remove “Cool patient if febrile”

CPG-A 11 Adult Seizures (EMT)

It was agreed to remove “Cool patient if febrile”. The seizure may be precipitated by hypoglycaemia therefore it is necessary to check blood glucose during seizure, it was agreed that the CPG should reflect this. The debate was reopened on blood glucose levels. It was felt that adult and Paediatric intervention levels should be the same.
All CPGs to be amended to the agreed glucose level for intervention.

CPG-A 57 Seizures/convulsions - Paediatric (OFA and EFR)

No changes were recommended for this CPG.

CPG-A 57 Seizures/convulsions Paediatric (EMT)

Blood glucose level to be confirmed for Paediatric patients (3 mmol/L or 4 mmol/L).
All CPGs to be amended to the agreed glucose level.
It was agreed this level would be confirmed by a Paediatrician, Lawrence Kenna agreed to follow up and come back to MAG following consultation with Paediatrician.

Resolution: That Delphi 8 CPGs be approved with the above amendments.

Moved: Macartan Hughes

Seconded: Lawrence Kenna

Carried Without dissent

3.3.2 Delphi 9a

CPG 14a – Major Emergency (Major Incident) First Ambulance Crew

Discussion ensued on Practitioner levels and it was agreed to use Practitioner 1 and Practitioner 2 (MIMMS Trained).

Methane message – standby to be included in box.

It was agreed to format the larger text boxes into bullet point format.

It was unanimously agreed that the first ambulance crew on scene at a Major Emergency would declare/standby a Major Emergency to ambulance control. It was then a HSE Management issue to proceed or otherwise.

CPG 14b – Major Emergency (Major Incident) Operational Control

It was agreed to include an ambulance circuit into diagram.

Add the following text to box at top right hand side of site layout: “If danger area identified”

Add text “PPE required” to end of text box at bottom left handside of site layout.

CPG 14c – Triage Sieve

Delete top left hand text box “trriage sieve is carried out at the site where the casualty is found”

Change Respiratory rates to “ <10 or >29.

Include an acknowledgement to MIMMS as a footnote on CPG.

CPG 14d – Triage Sort

Delete text box at top left hand side of CPG “Triage sort is carried out at the Casualty Clearing Station and beyond”.

Include an acknowledgement to MIMMS as a footnote on CPG.

Resolution: That Delphi 9a CPGs be approved with the above amendments.

Moved: Lawrence Kenna

Seconded: Declan Lonergan

Carried without dissent

5. AOB

Dr David Janes wished to thank PHECC for the informal MAG discussions group/seminar held on the 26th March and the positive benefits of the seminar to the progression of MAG issues.

He also wished to express his thanks to all MAG members that attended the Major car accident on the M7 motorway on March 27th. No other matters discussed.

The next MAG meeting is scheduled for Tuesday 8th May (13:00 – 19:00 hrs) and 9th May (9:30 – 16:00 hrs) in the PHECC Office, with overnight accommodation and dinner in the Kilashee house hotel on the 8th at 20:00 hrs.

Following representation it was agreed that the PHECC Office would notify the Chief Ambulance Officers and the DFB Chief Fire Officer of this meeting.

Signed:

Date:

Mr Mark Doyle
Chair

**Meeting Report of the PHECC Medical Advisory Group held at the
PHECC office Naas on Tuesday 8th and 9th May 2007**

Tuesday 8th May 13:00 – 19:00 hrs

Present:

John Burton
Gerry Bury
Mark Doyle
Macartan Hughes
David Janes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Cathal O'Donnell
Vincent O'Connor

Apologies:

Mags Bourke
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
Geoff Keye
Richard Lynch
Peter O'Connor
John O'Donnell
Danny O'Regan
Martin O'Reilly
Paul Robinson
Brendan Whelan

In attendance:

Jacqueline Egan,
Sharon Gallagher,
Geoff King,
Brian Power

1. Chair's Business and apologies:

The Chair thanked members for giving up their time to attend this two-day meeting and appreciated their efforts in acknowledging the development of the CPGs.

The Director outlined that the Vice-Chair Dr Mags Bourke had opted to stand-down from her role as Vice-Chair and therefore a formal proposal was needed to replace this position. It was agreed that all MAG members would be corresponded with regarding expressing their interest in the role of Vice-Chair or nominate a member for the role with that member's permission. The process thereon will depend on the level of interest and all members will be kept informed of process following first correspondence.

2. Meeting Report and matters arising

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 10th April 2007 be agreed.

Moved: Vincent O'Connor
Carried without dissent

Seconded: David Janes

The concern raised in the April MAG Meeting Report was discussed and the Director outlined that the key issue was the concern for the actual need for the use of IM Morphine at EMT level. The previous wording at the April MAG meeting “*The use of IM Morphine at Paramedic and EMT level for specific providers may be approved by PHECC upon application to the Director*” was deemed by the Director as not possible i.e. to approve specific providers individually for one particular CPG or drug administration. Detailed and extensive discussion ensued and it was agreed that pain relief with morphine for patients in inaccessible locations was appropriate for EMT and Paramedic levels. Appropriate wordings would be developed for consideration by MAG. Brian Power outlined that Methoxyflurane which is used extensively in Australia for pre-hospital pain relief, is an alternative to Morphine. He pointed out however that Methoxyflurane is not currently available or licenced for use in Ireland.

6. CPD

6.1 CPD

The Director briefed the group on the “Continuing Professional Development – PHECC Working Paper” which was tabled. Discussion ensued on two important issues of firstly conceptualising the CPD model and secondly the funding required. It was noted that specific CPD components need to be mandatory i.e. Cardiac First Response and that the Clinical Care Committee had undertaken to develop the CPD process. The Director requested MAG members to consider this paper and its merits and to come back with feedback.

6.2 Summary of feedback from 4th Advanced Paramedic Course by Prof Bury

Prof Bury did a presentation on feedback received from the 4th Cohort of Advanced Paramedics at NATS/UCD. Key issues that were found included the importance of log books and the issue of “adequate kits”. The Director outlined that PHECC may be able to provide some assistance to further develop the research presented. Following discussion by members on the issue of developing a framework for feedback on the appropriateness of CPGs, the Chair agreed to write to the Chair of the Clinical Care Committee, Mr Sean Creamer as per outlined below:

“To guide the development of CPGs and their appropriate application to the various practitioner levels on the Register, MAG feels there is a requirement for a system of feedback. A number of questions arise:

- 1. What framework exists for implementation of new CPGs at the different practitioner levels?*
- 2. What systems exist, or are planned, to capture issues relating to practitioner experience of new CPGs?*
- 3. How is it envisaged that this information feeds back to the development process?”*

Resolution: That a letter outlining the above 3 queries be sent to the Chair of Clinical Care for their guidance on the issue.

Proposed: Vincent O’Connor
Carried without dissent

Seconded: Cathal O’Donnell

- 6.3** Prof Bury’s presentation focused on the use of IO during the AP internship. The findings were positive and supportive of the use of IO particularly for cardiac arrest. Cathal O’Donnell outlined the protocol in Mid West Regional Hospital for cardiac arrest where IO access is first line vascular access for both adult and paediatric cardiac arrest and multisystem trauma.

Resolution: The protocol for IO access for adult cardiac arrest to be the same as agreed for paediatric IO access.

Proposed: Vincent O’Connor
Carried without dissent

Seconded: Cathal O’Donnell

7. Update by Director

The Director updated the group on the following issues as per inclusions in the meeting papers:

- 2007 Education and Training Standards
- Framework Poster
- Out of Hospital Cardiac Arrest Register
- Research Clearing House

3. Batch 9 CPGs

Batch 9 was included in the meeting papers for review of members prior to the Delphi process.

Mr Brian Power highlighted that in CPG 23 there was a need for direction on the number of shocks for hypothermia. Prof Bury agreed to look into the evidence re same and come back to Brian Power with advice.

CPG 22 – Replace pulmonary distress with respiratory distress.

CPG-Ms

Eight CPG-Ms developed by ISIC were presented for review.

4. CPG Review

4.1 Delphi 9b.

CPG A 13 Hypovolaemic shock Adult

The red text box at bottom of CPG was revised to read: *“Paramedics are authorised to continue an established infusion in the absence of an Advanced Paramedic or Medical Practitioner during transportation.”*

It was agreed to replace the title “hypovolaemia” with “Shock due to blood loss”.

It was agreed to replace blunt trauma with head injury.

It was agreed to administer Hartmann’s solution for “head injury” with GCS of ≤ 8 to maintain BP of 120 systolic”.

It was agreed to administer fluids to maintain systolic BP at 90-100 mmHg or palpable radial pulse for hypovolaemia other than severe head injury. In line with maintaining minimum BP it was agreed to remove an upper limit on IV fluids for hypovolaemia.

It was agreed to develop a separate CPG for Meningitis – with starting text box “Septic Shock” a reference box to include masks and goggles be included.

Kevin Flannery to come back with evidence on Head Injury, GCS score and maintaining BP 120 systolic.

CPG 15a External Haemorrhage – Adult

It was agreed to delete the following text boxes “penetrating trauma” and “Class II shock or greater” and replace with one box - “Significant blood loss”.

Replace “wound >10mm” with “small superficial injury” .

Under final red text box it was agreed to include “Consider discharge”.

It was agreed to permit tourniquet application by paramedics.

CPG 15b External Haemorrhage – Paediatric

Discussion ensued on the age category for 14 to 16 year olds and the issue of treat and transport or refusal of treatment or treat and discharge of paediatrics. Capacity, consent and competence needs to be looked at by MAG specifically. It was agreed to change CPG in line with changes to adult version.

CPG 3e Traumatic Cardiac Arrest – Adult

Discussion ensued on fitting this CPG into other Asystole and Cardiac Arrest CPGs. Brian Power agreed to link up with Cathal O'Donnell, Gerry Bury and Mark Doyle in relation to development of above. Brian Power agreed to circulate position paper of traumatic cardiac arrest produced by the National Association of EMS Physicians.

Resolution: That Delphi 9b be approved by the MAG with the above amendments.

Proposed: Vincent O'Connor
Carried without dissent

Seconded: Cathal O'Donnell

4.2 Delphi 10

CPG 13e Glycaemic Emergencies – Adult (OFA and EFR)

It was agreed to include "A" with "V" in the AVPU scale text box.

It was agreed to insert an arrow back up from reassess to AVPU scale and include "repeat x1 prn" into the glucose text box.

CPG 18 Cerebrovascular accident (CVA) (EMT)

It was agreed that "vital signs" and "blood glucose check" need to be included on the algorithm. Brian Power confirmed that EMT levels will be trained to carry out glucometry.

CPG 18 Cerebrovascular accident (CVA) (OFA and EFR)

Following discussion on EFR and OFA skill levels it was agreed to delete this CPG for these levels.

Wednesday 9th May 2007
09:30 – 16:00 hrs

Present:

Mark Doyle
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Cathal O'Donnell
Vincent O'Connor

Apologies:

John Burton
Gerry Bury
Mags Bourke
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
David Janes
Geoff Keye
Richard Lynch
Peter O'Connor
John O'Donnell
Danny O'Regan
Martin O'Reilly
Paul Robinson
Brendan Whelan

In attendance:

Jacqueline Egan,
Sharon Gallagher,
Geoff King,
Brian Power

4.2 Delphi 10 (continued)

CPG 16 Epistaxis (EMT, P and AP)

Concerns were expressed with insertion objectives into the nostrils. Mark Doyle made distinction between trauma nose bleed and medical nose bleed. It was agreed to delete the "Foley catheter" text box and delete the "pack" text box from the CPG.

CPG 17a Poisons – Adult (EMT and P)

It was agreed to include a text box to read "caution on oral intake" above the "sips of water or milk" text box. After the red text box "cool area" it was agreed to include a box reading "consider decontamination".

Discussion ensued on contaminated patients and transportation.

It was agreed to change the phrase "absolutely no oxygen" to instead read "do not give oxygen".

In relation to the note on bottom of page - "*CPG A3, Inadequate respirations, authorises the administration of Naloxone for opiate overdose*" – it was agreed to include this in the CPG as a decision arm.

CPG 17a Poisons – Adult (AP)

It was agreed to include all the changes as outlined in CPG 17a Poisons (EMT & P).

Delete the "food poisoning" arm of the CPG.

The second and subsequent dose of Midazolam was changed to 2.5 mg IV and 5mg IM. It was also agreed to include Tricyclic seizures with wide QRS arrhythmia for indication for sodium bicarbonate.

It was agreed to remove "physical restraint" from the CPG and replace with "go to behavioural CPG".

Change "rousable drowsiness within 10 mins" to "Patient still agitated and unmanageable".

Under "psychostimulant" insert "symptomatic".

The alcohol arm to be deleted unless evidence can support its inclusion.

CPG 18 Cerebrovascular accident (P & AP)

It was agreed to include – "transport patient to hospital with specialised stroke unit (under local protocol). Delete reference to CT scan.

Include blood glucose check.

CPG 9b Umbilical Cord Complications (P & A)

This CPG was agreed subject to an obstetric opinion.

Resolution: That Delphi 10 be approved subject to agreed changes.

Proposed: Fergus McCarron **Seconded:** Macartan Hughes

Carried without dissent.

4.4 Delphi 11

CPG A 3 Inadequate Respirations - Adult

Change "dyspnoea" text box at top to read "inadequate respirations"

Change Epinephrine option to "Consider Magnesium sulphate IV"

It was agreed to include the following in the "Consider advanced airway LMA/LT text box" – "if all of – GCS = 3, SpO2 status <92%, inability to ventilate with BVM & RR ≤ 9".

Include "Request ALS early".

"Congestion/rales" change to "congestion/crepitations".

Move "tension pneumothorax confirmed" – to below "inadequate rate or depth".

In "silent chest" diamond change "&" to "or".

Dose of GTN – change to 0.8mg initial dose and repeat by one prn. Brian Power to check dose.

Remove consider Treat and discharge box and change text box above this to read “Alert, no evidence of respiratory distress”, include arrow with “no” from this text box.

Include salbutamol nebule as an option with mild Bronchospasm arm.

CPG A3 Inadequate Respirations – Adult (EMT)

Change “dyspnoea” text box at top to read inadequate respirations.

Delete “Asymmetrical movement”.

A discussion ensued on the colour on medications on CPGs. It was agreed that the colour code of the medication on the CPGs will reflect the clinical levels that apply to the specific CPG only.

Change “consider Paramedic” to “request Paramedic” for EMT level

Insert the emergency asthma box as per CPG-A levels P & AP.

CPG A3 Inadequate Respirations – Adult (OFA and EFR)

Delete the equipment list. Insert “respiratory rate <10” into “inadequate rate and depth”. Reverse “history of asthma” and “audible wheeze”.

Discussion ensued on the use of bag valve mask (BVM) at EFR level and it was agreed that MAG correspond with the Clinical Care Committee “*to recommend that EFRs are trained to use BVMs as a two person skill and that the 2007 PHECC Education and training standards be adjusted to reflect this*”.

Resolution: That a letter recommending the above be sent to the Chair of the Clinical Care Committee.

Proposed: Cathal O’Donnell

Seconded: Macartan Hughes

Carried without dissent

CPG A1 Advanced Airway Management – Adult (P & AP)

It was agreed to include the following in a new text box to read “Consider advanced airway LMA/LT text box” – “if all of below – GCS =3, SpO2 status <92%, inability to ventilate with BVM and RR ≤9”.

CPG A1 Advanced Airway Management – Paediatric (AP)

It was agreed to change the first text box from “Prolonged resuscitation” to “Prolonged CPR”.

It was agreed to delete NG tube. It was agreed to insert LT into LMA box.

It was agreed that only one intubation attempt be permitted and only one LMA/LT attempt be permitted as portrayed in the CPG.

CPG A 52 Symptomatic Bradycardia Paediatric (EMT, P and AP)

It was agreed to delete Atropine from the CPG. Add “symptomatic” prior to “bradycardia”.

It was agreed to delete “mottling” from the “Signs of poor perfusion” text box.

It was agreed to include a ventilation text box between “oxygen” and “severe cardiorespiratory compromise”. It was agreed to insert Fluid challenge 20 mL/kg IV prior to epinephrine. It was agreed to insert a decision diamond relating to “<8 years and HR <60” prior to “CPR”. Delete right arm.

CPG 12a Mental Health Emergency - AP

It was agreed to reword red text to read the following text “ Co-operate as appropriate with Medical or Nursing team”.

It was agreed to change the term “involuntary” to “assisted” admission. Discussion ensued on the role of AP on assisted admissions.

Mr Brian Power agreed to come back with more information on the administration of Halperidol and the CPG following expert advice. It was agreed Lorazepam 2 mg PO was also an option.

CPG 12a Mental Health Emergency – (EMT & P)

Change “involuntary admission” to “assisted admission”. Change wording re medical & nursing team as agreed at AP level.

CPG 12b Behavioural Emergency (EMT, P and P)

It was agreed that legal opinion was required for the implication of the mental health and behavioural CPGs in relation to the Mental Health Act.

Resolution: That Delphi 11 be approved subject to the agreed amendments.

Proposed: Vincent O'Connor **Seconded:** Macartan Hughes
Carried without dissent.

5. ePCR

Ms Jacqueline Egan distributed a paper – “Patient Care Report Status Update” and presented to the group on the current developments and status of the PHECC PCR, ePCR, Reporting Module, Training Application, Data Entry Application and the use of the Digital Pen Technology with the PCR.

Ms Egan outlined that there will be a need for feedback and guidance on the reporting functionality at various levels. She also stated that National Implementation of the PCR System is the next step and we are in discussion with the HSE in this regard.

Mr Mark Doyle and Dr Cathal O'Donnell complimented Jacqueline Egan on the ePCR project and how efficient and useful it would be to the broader health services, not just the Ambulance services.

8. AOB

It was agreed that the next MAG meeting take place over the coming four weeks, all members will be corresponded regarding dates and that the Agenda will be specific to CPG and Delphi approvals.

Signed:

Date:

Mr. Mark Doyle
Chair

**Meeting Report of the PHECC Medical Advisory Group held at the
PHECC office Naas on Tuesday 8th and 9th May 2007**

Tuesday 8th May 13:00 – 19:00 hrs

Present:

John Burton
Gerry Bury
Mark Doyle
Macartan Hughes
David Janes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Cathal O'Donnell
Vincent O'Connor

Apologies:

Mags Bourke
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
Geoff Keye
Richard Lynch
Peter O'Connor
John O'Donnell
Danny O'Regan
Martin O'Reilly
Paul Robinson
Brendan Whelan

In attendance:

Jacqueline Egan,
Sharon Gallagher,
Geoff King,
Brian Power

1. Chair's Business and apologies:

The Chair thanked members for giving up their time to attend this two-day meeting and appreciated their efforts in acknowledging the development of the CPGs.

The Director outlined that the Vice-Chair Dr Mags Bourke had opted to stand-down from her role as Vice-Chair and therefore a formal proposal was needed to replace this position. It was agreed that all MAG members would be corresponded with regarding expressing their interest in the role of Vice-Chair or nominate a member for the role with that member's permission. The process thereon will depend on the level of interest and all members will be kept informed of process following first correspondence.

2. Meeting Report and matters arising

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 10th April 2007 be agreed.

Moved: Vincent O'Connor
Carried without dissent

Seconded: David Janes

The concern raised in the April MAG Meeting Report was discussed and the Director outlined that the key issue was the concern for the actual need for the use of IM Morphine at EMT level. The previous wording at the April MAG meeting “*The use of IM Morphine at Paramedic and EMT level for specific providers may be approved by PHECC upon application to the Director*” was deemed by the Director as not possible i.e. to approve specific providers individually for one particular CPG or drug administration. Detailed and extensive discussion ensued and it was agreed that pain relief with morphine for patients in inaccessible locations was appropriate for EMT and Paramedic levels. Appropriate wordings would be developed for consideration by MAG. Brian Power outlined that Methoxyflurane which is used extensively in Australia for pre-hospital pain relief, is an alternative to Morphine. He pointed out however that Methoxyflurane is not currently available or licenced for use in Ireland.

6. CPD

6.1 CPD

The Director briefed the group on the “Continuing Professional Development – PHECC Working Paper” which was tabled. Discussion ensued on two important issues of firstly conceptualising the CPD model and secondly the funding required. It was noted that specific CPD components need to be mandatory i.e. Cardiac First Response and that the Clinical Care Committee had undertaken to develop the CPD process. The Director requested MAG members to consider this paper and its merits and to come back with feedback.

6.2 Summary of feedback from 4th Advanced Paramedic Course by Prof Bury

Prof Bury did a presentation on feedback received from the 4th Cohort of Advanced Paramedics at NATS/UCD. Key issues that were found included the importance of log books and the issue of “adequate kits”. The Director outlined that PHECC may be able to provide some assistance to further develop the research presented. Following discussion by members on the issue of developing a framework for feedback on the appropriateness of CPGs, the Chair agreed to write to the Chair of the Clinical Care Committee, Mr Sean Creamer as per outlined below:

“To guide the development of CPGs and their appropriate application to the various practitioner levels on the Register, MAG feels there is a requirement for a system of feedback. A number of questions arise:

- 1. What framework exists for implementation of new CPGs at the different practitioner levels?*
- 2. What systems exist, or are planned, to capture issues relating to practitioner experience of new CPGs?*
- 3. How is it envisaged that this information feeds back to the development process?”*

Resolution: That a letter outlining the above 3 queries be sent to the Chair of Clinical Care for their guidance on the issue.

Proposed: Vincent O’Connor
Carried without dissent

Seconded: Cathal O’Donnell

- 6.3** Prof Bury’s presentation focused on the use of IO during the AP internship. The findings were positive and supportive of the use of IO particularly for cardiac arrest. Cathal O’Donnell outlined the protocol in Mid West Regional Hospital for cardiac arrest where IO access is first line vascular access for both adult and paediatric cardiac arrest and multisystem trauma.

Resolution: The protocol for IO access for adult cardiac arrest to be the same as agreed for paediatric IO access.

Proposed: Vincent O’Connor
Carried without dissent

Seconded: Cathal O’Donnell

7. Update by Director

The Director updated the group on the following issues as per inclusions in the meeting papers:

- 2007 Education and Training Standards
- Framework Poster
- Out of Hospital Cardiac Arrest Register
- Research Clearing House

3. Batch 9 CPGs

Batch 9 was included in the meeting papers for review of members prior to the Delphi process.

Mr Brian Power highlighted that in CPG 23 there was a need for direction on the number of shocks for hypothermia. Prof Bury agreed to look into the evidence re same and come back to Brian Power with advice.

CPG 22 – Replace pulmonary distress with respiratory distress.

CPG-Ms

Eight CPG-Ms developed by ISIC were presented for review.

4. CPG Review

4.1 Delphi 9b.

CPG A 13 Hypovolaemic shock Adult

The red text box at bottom of CPG was revised to read: *“Paramedics are authorised to continue an established infusion in the absence of an Advanced Paramedic or Medical Practitioner during transportation.”*

It was agreed to replace the title “hypovolaemia” with “Shock due to blood loss”.

It was agreed to replace blunt trauma with head injury.

It was agreed to administer Hartmann’s solution for “head injury” with GCS of ≤ 8 to maintain BP of 120 systolic”.

It was agreed to administer fluids to maintain systolic BP at 90-100 mmHg or palpable radial pulse for hypovolaemia other than severe head injury. In line with maintaining minimum BP it was agreed to remove an upper limit on IV fluids for hypovolaemia.

It was agreed to develop a separate CPG for Meningitis – with starting text box “Septic Shock” a reference box to include masks and goggles be included.

Kevin Flannery to come back with evidence on Head Injury, GCS score and maintaining BP 120 systolic.

CPG 15a External Haemorrhage – Adult

It was agreed to delete the following text boxes “penetrating trauma” and “Class II shock or greater” and replace with one box - “Significant blood loss”.

Replace “wound >10mm” with “small superficial injury” .

Under final red text box it was agreed to include “Consider discharge”.

It was agreed to permit tourniquet application by paramedics.

CPG 15b External Haemorrhage – Paediatric

Discussion ensued on the age category for 14 to 16 year olds and the issue of treat and transport or refusal of treatment or treat and discharge of paediatrics. Capacity, consent and competence needs to be looked at by MAG specifically. It was agreed to change CPG in line with changes to adult version.

CPG 3e Traumatic Cardiac Arrest – Adult

Discussion ensued on fitting this CPG into other Asystole and Cardiac Arrest CPGs. Brian Power agreed to link up with Cathal O'Donnell, Gerry Bury and Mark Doyle in relation to development of above. Brian Power agreed to circulate position paper of traumatic cardiac arrest produced by the National Association of EMS Physicians.

Resolution: That Delphi 9b be approved by the MAG with the above amendments.

Proposed: Vincent O'Connor
Carried without dissent

Seconded: Cathal O'Donnell

4.2 Delphi 10

CPG 13e Glycaemic Emergencies – Adult (OFA and EFR)

It was agreed to include "A" with "V" in the AVPU scale text box.

It was agreed to insert an arrow back up from reassess to AVPU scale and include "repeat x1 prn" into the glucose text box.

CPG 18 Cerebrovascular accident (CVA) (EMT)

It was agreed that "vital signs" and "blood glucose check" need to be included on the algorithm. Brian Power confirmed that EMT levels will be trained to carry out glucometry.

CPG 18 Cerebrovascular accident (CVA) (OFA and EFR)

Following discussion on EFR and OFA skill levels it was agreed to delete this CPG for these levels.

Wednesday 9th May 2007
09:30 – 16:00 hrs

Present:

Mark Doyle
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Cathal O'Donnell
Vincent O'Connor

Apologies:

John Burton
Gerry Bury
Mags Bourke
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
David Janes
Geoff Keye
Richard Lynch
Peter O'Connor
John O'Donnell
Danny O'Regan
Martin O'Reilly
Paul Robinson
Brendan Whelan

In attendance:

Jacqueline Egan,
Sharon Gallagher,
Geoff King,
Brian Power

4.2 Delphi 10 (continued)

CPG 16 Epistaxis (EMT, P and AP)

Concerns were expressed with insertion objectives into the nostrils. Mark Doyle made distinction between trauma nose bleed and medical nose bleed. It was agreed to delete the "Foley catheter" text box and delete the "pack" text box from the CPG.

CPG 17a Poisons – Adult (EMT and P)

It was agreed to include a text box to read "caution on oral intake" above the "sips of water or milk" text box. After the red text box "cool area" it was agreed to include a box reading "consider decontamination". Discussion ensued on contaminated patients and transportation. It was agreed to change the phrase "absolutely no oxygen" to instead read "do not give oxygen".

In relation to the note on bottom of page - "*CPG A3, Inadequate respirations, authorises the administration of Naloxone for opiate overdose*" – it was agreed to include this in the CPG as a decision arm.

CPG 17a Poisons – Adult (AP)

It was agreed to include all the changes as outlined in CPG 17a Poisons (EMT & P).

Delete the "food poisoning" arm of the CPG.

The second and subsequent dose of Midazolam was changed to 2.5 mg IV and 5mg IM. It was also agreed to include Tricyclic seizures with wide QRS arrhythmia for indication for sodium bicarbonate.

It was agreed to remove "physical restraint" from the CPG and replace with "go to behavioural CPG".

Change "rousable drowsiness within 10 mins" to "Patient still agitated and unmanageable".

Under "psychostimulant" insert "symptomatic".

The alcohol arm to be deleted unless evidence can support its inclusion.

CPG 18 Cerebrovascular accident (P & AP)

It was agreed to include – "transport patient to hospital with specialised stroke unit (under local protocol). Delete reference to CT scan.

Include blood glucose check.

CPG 9b Umbilical Cord Complications (P & A)

This CPG was agreed subject to an obstetric opinion.

Resolution: That Delphi 10 be approved subject to agreed changes.

Proposed: Fergus McCarron **Seconded:** Macartan Hughes

Carried without dissent.

4.4 Delphi 11

CPG A 3 Inadequate Respirations - Adult

Change "dyspnoea" text box at top to read "inadequate respirations"

Change Epinephrine option to "Consider Magnesium sulphate IV"

It was agreed to include the following in the "Consider advanced airway LMA/LT text box" – "if all of – GCS = 3, SpO2 status <92%, inability to ventilate with BVM & RR ≤ 9".

Include "Request ALS early".

"Congestion/rales" change to "congestion/crepitations".

Move "tension pneumothorax confirmed" – to below "inadequate rate or depth".

In "silent chest" diamond change "&" to "or".

Dose of GTN – change to 0.8mg initial dose and repeat by one prn. Brian Power to check dose.

Remove consider Treat and discharge box and change text box above this to read “Alert, no evidence of respiratory distress”, include arrow with “no” from this text box.

Include salbutamol nebule as an option with mild Bronchospasm arm.

CPG A3 Inadequate Respirations – Adult (EMT)

Change “dyspnoea” text box at top to read inadequate respirations.

Delete “Asymmetrical movement”.

A discussion ensued on the colour on medications on CPGs. It was agreed that the colour code of the medication on the CPGs will reflect the clinical levels that apply to the specific CPG only.

Change “consider Paramedic” to “request Paramedic” for EMT level

Insert the emergency asthma box as per CPG-A levels P & AP.

CPG A3 Inadequate Respirations – Adult (OFA and EFR)

Delete the equipment list. Insert “respiratory rate <10” into “inadequate rate and depth”. Reverse “history of asthma” and “audible wheeze”.

Discussion ensued on the use of bag valve mask (BVM) at EFR level and it was agreed that MAG correspond with the Clinical Care Committee “*to recommend that EFRs are trained to use BVMs as a two person skill and that the 2007 PHECC Education and training standards be adjusted to reflect this*”.

Resolution: That a letter recommending the above be sent to the Chair of the Clinical Care Committee.

Proposed: Cathal O’Donnell

Seconded: Macartan Hughes

Carried without dissent

CPG A1 Advanced Airway Management – Adult (P & AP)

It was agreed to include the following in a new text box to read “Consider advanced airway LMA/LT text box” – “if all of below – GCS =3, SpO2 status <92%, inability to ventilate with BVM and RR ≤9”.

CPG A1 Advanced Airway Management – Paediatric (AP)

It was agreed to change the first text box from “Prolonged resuscitation” to “Prolonged CPR”.

It was agreed to delete NG tube. It was agreed to insert LT into LMA box.

It was agreed that only one intubation attempt be permitted and only one LMA/LT attempt be permitted as portrayed in the CPG.

CPG A 52 Symptomatic Bradycardia Paediatric (EMT, P and AP)

It was agreed to delete Atropine from the CPG. Add “symptomatic” prior to “bradycardia”.

It was agreed to delete “mottling” from the “Signs of poor perfusion” text box.

It was agreed to include a ventilation text box between “oxygen” and “severe cardiorespiratory compromise”. It was agreed to insert Fluid challenge 20 mL/kg IV prior to epinephrine. It was agreed to insert a decision diamond relating to “<8 years and HR <60” prior to “CPR”. Delete right arm.

CPG 12a Mental Health Emergency - AP

It was agreed to reword red text to read the following text “ Co-operate as appropriate with Medical or Nursing team”.

It was agreed to change the term “involuntary” to “assisted” admission. Discussion ensued on the role of AP on assisted admissions.

Mr Brian Power agreed to come back with more information on the administration of Halperidol and the CPG following expert advice. It was agreed Lorazepam 2 mg PO was also an option.

CPG 12a Mental Health Emergency – (EMT & P)

Change “involuntary admission” to “assisted admission”. Change wording re medical & nursing team as agreed at AP level.

CPG 12b Behavioural Emergency (EMT, P and P)

It was agreed that legal opinion was required for the implication of the mental health and behavioural CPGs in relation to the Mental Health Act.

Resolution: That Delphi 11 be approved subject to the agreed amendments.

Proposed: Vincent O'Connor **Seconded:** Macartan Hughes
Carried without dissent.

5. ePCR

Ms Jacqueline Egan distributed a paper – “Patient Care Report Status Update” and presented to the group on the current developments and status of the PHECC PCR, ePCR, Reporting Module, Training Application, Data Entry Application and the use of the Digital Pen Technology with the PCR.

Ms Egan outlined that there will be a need for feedback and guidance on the reporting functionality at various levels. She also stated that National Implementation of the PCR System is the next step and we are in discussion with the HSE in this regard.

Mr Mark Doyle and Dr Cathal O'Donnell complimented Jacqueline Egan on the ePCR project and how efficient and useful it would be to the broader health services, not just the Ambulance services.

8. AOB

It was agreed that the next MAG meeting take place over the coming four weeks, all members will be corresponded regarding dates and that the Agenda will be specific to CPG and Delphi approvals.

Signed:

Date:

Mr. Mark Doyle
Chair

**Meeting Report of the PHECC Medical Advisory Group held at the PHECC
office Naas on Tuesday 12th June 2007**

Tuesday 12th June 10:30 – 16:00 hrs

Present:

John Burton
Mark Doyle
Macartan Hughes
Declan Lonergan
Richard Lynch
Vincent O'Connor
Danny O'Regan
Brendan Whelan

Apologies:

Mags Bourke
Gerry Bury
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
David Janes
Lawrence Kenna
Geoff Keye
Fergus McCarron
Peter O'Connor
Cathal O'Donnell
John O'Donnell
Martin O'Reilly
Michael Seaman
Paul Robinson
Julie Woods

In attendance:

Jacqueline Egan
Kevin Flannery
Sharon Gallagher
Brian Power

1. Chair's Business and apologies:

Following the last MAG meeting only one nomination had been received from members for election as Vice Chair following Dr Mags Bourke option to stand down.

Resolution: That Mr Cathal O'Donnell be elected as Vice-Chair of the Medical Advisory Group.

Proposed: John Burton
Carried without dissent

Seconded: Richard Lynch

2. Meeting Report and matters arising

2.1.0 The Chair informed members that the letters to the Clinical Care Committee regarding the following two issues had been sent last month:

2.1.1 *“To guide the development of CPGs and their appropriate application to the various practitioner levels on the Register, MAG feels there is a requirement for a system of feedback. A number of questions arise:*

1. *What framework exists for implementation of new CPGs at the different practitioner levels?*
2. *What systems exist, or are planned, to capture issues relating to practitioner experience of new CPGs?*
3. *How is it envisaged that this information feeds back to the development process?”*

2.1.2 MAG correspond with the Clinical Care Committee *“to recommend that EFRs are trained to use BVMs as a two person skill and that the 2007 PHECC Education and training standards be adjusted to reflect this”.*

The Chair of the Clinical Care Committee had acknowledged receipt of same but as the Committee had not convened a meeting since the correspondence, no feedback was available as yet on the issues.

2.2.1 **Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 8th & 9th May 2007 be agreed.**

Moved: Danny O'Regan
Carried without dissent

Seconded: Macartan Hughes

2.2.2 Traumatic cardiac arrest

From 4.1 on minutes Brian Power had agreed to contact Mark Doyle, Gerry Bury and Cathal O'Donnell to discuss modifications of traumatic cardiac arrest. Brian Power circulated feedback from Mark Doyle and Prof Gerry Bury and the modified CPG 3e (Adult P & AP). Prof Bury had recommended that an additional element (unwitnessed traumatic cardiac arrest following blunt trauma) be added to the “definitive indicators of death” in CPG 3c. The meeting felt that this did not capture the nuisances required and suggested changes to CPG 3e instead. It was agreed to change the red text box to read “Consider ceasing resuscitation” – move this text box to centre.

Move the text box “On commencing CPR and ALS” up further in right hand algorithym.

Discussion ensued on transport after penetrating traumatic cardiac arrest – should transport immediately. It was agreed to insert “No response to

ALS within 15 minutes” – “Consider ceasing resuscitation” – should be rapid transport with ALS enroute.

CPGs as per Brian’s document distributed - agreed subject to the above amendments.

Resolution: CPG 3e be agreed

Proposed: Declan Lonergan

Seconded: Brendan Whelan

Item 8 AOB from meeting report – Number of shocks for hypothermia – Prof Gerry Bury advised Brian Power that “three” was the appropriate maximum number of shocks for VF in severe hypothermia.

IO presentation from last meeting – the Emergency Depts in Regional Hospital Limerick and in Waterford Regional Hospital are now using IO.

2.2.3 Following discussion it was reiterated by the Chair that PHECC would come back to MAG (seeking their direction) with appropriate wording on the administration of morphine at levels other than Advanced Paramedic

3.0 Batch 10 CPGs

Brian Power asked members to review these CPGs before they are sent out formally for the next Delphi 14.

4.1 CPG Ps & CPG Ms

2007 Education and Training Standards – DFB started training on the 2007 standards. Glucagon IM & Epinephrine (1:1 000) IM are allowed legally for use at Paramedic level.

These CPGs were developed in the interim to allow the current class of DFB and the upcoming classes to carry out the administration of these medications.

Resolution: That CPG-Ps be approved by MAG and forwarded to Council for ratification.

Proposed: Brendan Whelan

Seconded: Vincent O’Connor

4.2 CPG - Ms

It was advised by the Chair that these CPG-Ms need to be sent through the Delphi process to all MAG members for their review and approval for MAG. He outlined that the Delphi should also include practitioners that these CPG-Ms are aimed at.

It was noted that confirmation needed to be sought from Dr Mags Bourke as to her role on MAG, if she has resigned just as Vice-Chair or from the Committee entirely. If this is the case then a replacement Anaesthetist would have to be sought. Clarification from Mags Bourke will be sought by the PHECC Office prior to the next MAG.

5.1 Delphi 12

CPG 19 Post resuscitation Care – Adult Levels 1-3

It was agreed to remove “cooling” at these levels. The Post resuscitation rates of 10-12 breaths was agreed.

CPG 19 Post Resuscitation Care – Adult Levels 4-6

It was agreed to remove Haliperidol from this CPG. It was agreed to separate out EMT level for this CPG.

Following extensive discussion it was agreed to include “commence active cooling for post VF/VT arrest unresponsive patients. Also include “check GCS” on CPG. Change “Pulse <60” to “symptomatic bradycardia” and on equipment list include “(tympanic)” and “cold packs”.

Discussion ensued on the issue on the number of practitioners/responders on site to assist with cardiac arrest management. It was agreed to amend the wording to read “Initiate mobilisation of additional practitioners /responders (ideally 3/4).

It was agreed to insert this on all Cardiac Arrest CPGs.

Edit text box on amiodarone to read - Consider Amiodarone, 1 mg/min, IV infusion if persistent tachyarrhythmia.

CPG 21 Haemorrhage in pregnancy prior to delivery – Levels 5 & 6

Include O2 in algorithm.

Replace word “vulva” with “perinium”.

CPG 20 Post Partum Haemorrhage – Levels 5 & 6

Discussion ensued re catheterisation pre-hospital. It was agreed that an expert obstetric opinion would be sought regarding the procedure of catheterisation pre-hospital (as per all maternity CPGs as agreed at last MAG meeting).

Mr Danny O’Regan suggested the recently appointed Consultant Obstetrician in Cork’s new Maternity hospital who had tutored paramedics in the UK may be agreeable to review same. Brian Power outlined that all maternity CPGs were sent to a midwife nurse manager for comment. The CPG would then be forwarded to the Consultant Obstetrician in Cork.

Danny O'Regan agreed to take them informally in the mean time to the Obstetrician.

CPG 11a Altered Levels of Consciousness – CPG 11a Level 4

It was agreed to move up the text box “AVPU decision box” to the top of the algorithm under “maintain airway”. It was agreed to remove the “Go to CPG xx” text boxes on both sides of the algorithm and replace with one text box on either side stating “Go to appropriate CPG”.

CPG 11a Altered Levels of Consciousness – CPG 11a Level 2 & 3

Discussion ensued on benefits of FAST assessment. It was agreed that it was appropriate to include it in the CPG.

CPG 5a (i) Secondary Survey Trauma – Adult Levels 5 & 6

It was agreed to amend text box “monitor and record vital signs” to include “& GCS”.

Discussion ensued on markers for multi-systems trauma & RTS

It was agreed to change the figures to read as follows:

GCS < 13

RTS < 12

Kevin Flannery agreed to forward the relevant published article outlining the method of scoring to all members.

It was agreed to wait to make the decision on inclusion of RTS until all members have reviewed the literature from Kevin.

CPG 5a (i) Secondary Survey Trauma – Adult Level 4

Extensive discussion ensued on the discharging of patients at this level.

Insert obvious minor injury decision box at top of algorithm.

Insert “mechanism of injury” into marker for multisystem trauma information box.

CPG 5a (i) Secondary Survey Trauma – Adult Level 2 & 3

It was agreed that the CPGs on “Treat & Discharge” are key to decision making. It was stated that they will go through the Delphi Process on next Delphi.

Insert obvious minor injury decision box at top of algorithm.

Resolution: That Delphi 12 be agreed with the above amendments.

Proposed: Vincent O'Connor
Carried without dissent

Seconded: Danny O'Regan

5.2 Delphi 13

CPG 5a (ii) Secondary Survey Medical Levels 5 & 6

It was suggested that MEWS scores should be encouraged in this procedure. It was agreed to keep text box “examine body systems as appropriate” but delete “ Respiratory, Cardiovascular, Gastrointestinal, and Nervous”.

It was also agreed to soften wording in “markers identifying acutely unwell present” and make more inclusive for “sick” patients.

CPG 5a (ii) Secondary Survey Medical Level 4

It was agreed to move the text box “Record vital signs” up on the algorithm to underneath box “markers identifying acutely unwell present”.

The issue of the appropriate response to dispatch systems was discussed. It was agreed that at least Paramedic was the appropriate clinical level to be dispatched to emergency calls by the statutory services.

CPG 5a (ii) Secondary Survey Medical Levels 2 & 3

It was agreed to move the text box “Record vital signs” up on the algorithm to underneath box “markers identifying acutely unwell present”.

In text box with heading “Request Emergency Dispatch (RED) Card” change text in point 6 from “blood flowing out” to “active bleeding”.

CPG A 13 Hypovolaemia Adult Level 4

Discussion ensued on the requirement for this CPG. It was agreed that appropriate direction had to be given to EMTs and therefore the CPG was acceptable.

CPG 6a (i) Burns Management Paediatric (<13years) Levels 4, 5 & 6

Already agreed for adult – values have changed to (>10%) Kevin Flannery agreed to come back to MAG with further evidence on values.

The need to include/allow “time for irrigation” was discussed, it is more important for clinical burns to irrigate than to transport.

Under the IV access text box It was discussed that fluids should not be given <10% burns. It was agreed to delete left hand limb under IV access text box. Kevin Flannery agreed to come back to Mark with evidence on under 5 year olds not getting fluids.

CPG 6a (i) Burns Management Paediatric (<13years) Levels 2 & 3

It was agreed to take out Level 2 (OFA) from this CPG as they are not trained to treat paediatrics.

It was agreed to change Chemical incident to Chemical burns.

It was agreed to insert “call 999/112” on right arm also.

CPG 7a (i) Spinal Immobilisation – Paediatric Levels 5 & 6

The following issues were discussed; treat and discharge; age cut offs and “numbness and tingling in extremities”. Richard Lynch agreed to look at evidence for Paediatrics Spinal rule out and bring back to MAG.

CPG 7a (i) Spinal Immobilisation – Paediatric Level 3 & 4

It was agreed to amend the last text box to read as follows: “Consider Vaccum mattress and long board”.

The issue of removing helmet at this level was discussed. Brian Power agreed to consult with appropriate people involved in sports in relation to helmet removal and clinical levels involved.

It was agreed that the content of the Spinal immobilisation CPGs at these levels was in the main acceptable but the helmet removal issue needs to be resolved and brought back to MAG for agreement.

Resolution: That Delphi 13 be agreed (not including the spinal immobilisation CPGs) with the above amendments.

Proposed: Brendan Whelan
Carried without dissent

Seconded: Macartan Hughes

6. AOB

It was agreed that the next MAG meeting take place over the month of July (24th or 31st). All members will be corresponded regarding dates and that the Agenda will be specific to CPG and Delphi approvals.

Signed:

Date:

Mr. Mark Doyle
Chair

Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Thursday 30th August 2007

Thursday 30th August 14:00 – 18:30 hrs

Present:

Mark Doyle
Gerry Bury
Sean Creamer
Conor Egleston
Macartan Hughes
David Janes
Lawrence Kenna
Richard Lynch
Fergus McCarron
Vincent O'Connor
Cathal O'Donnell
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies:

John Burton
Stephen Cusack
Fergal Hickey
Geoff Keye
Declan Lonergan
Peter O'Connor
John O'Donnell
Danny O'Regan
Paul Robinson
Julie Woods
Kevin Flannery

In attendance:

Geoff King
Sharon Gallagher
Brian Power

1. Chair's Business and apologies:

The correspondence from Shane Mooney regarding Patella dislocation, pacing and cardioversion was discussed. It was agreed that these potential CPGs would be included in the possible list for the 4th Edition of the Clinical Handbook.

It was also agreed to include adenosine on the Medication schedule list in anticipation of its future use. Brian Power agreed to correspond with Mr Shane Mooney to notify him of MAG's decision.

2. Meeting Report and matters arising

2.1 The following amendments to the Meeting Report were noted:

Page 2 item 2.2.2 Traumatic cardiac arrest – typo – change “nuisances” to “nuances”.

Page 6 item 5.2 CPG 6a (i) paragraph 2 – change “clinical burns” to “chemical burns”.

Page 6 CPG 5a Secondary survey Level 4.

The final sentence on this paragraph was discussed and it was agreed this sentence should not have been included and therefore should be disregarded in the MAG meeting Report June 2007.

The issue of the recommendation of 2 practitioners of minimum paramedic level on emergency statutory ambulances was discussed. It would be difficult to implement the CPGs unless these practitioners are available. It was agreed that a resolution be sent to Council, MAG recommends "that all emergency ambulances should be crewed by at least one registered Paramedic. This should evolve to two registered Paramedics in the long term to meet the standards required by CPGs".

The Chair agreed to draft a statement on the above discussion and send to Clinical Care.

Resolution: That the MAG forward a recommendation to the Clinical Care Committee for ratification by Council: *"that all emergency ambulances should be crewed by at least one registered Paramedic. This should evolve to two registered Paramedics in the long term to meet the standards required by CPGs"*.

Moved: Sean Creamer
Carried without dissent

Seconded: David Janes

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 12th June 2007 be agreed.

Moved: Brendan Whelan
Carried without dissent

Seconded: Vincent O'Connor

2.2 Matters arising

2.2.1 CPG 3e

Mr David Janes asked for clarification on traumatic Cardiac arrest. The issue of blunt trauma and penetrating trauma and ceasing resuscitation was discussed. It was agreed to move the transport box up in the algorithm. Mr Brian Power agreed to amend same.

2.2.2 Stauts of training on Glucagon, LMA/LT and Salbutamol

Mr Fergus McCarron asked at what stage the current status of Glucagon, LMA/LT and salbutamol were in relation to training. The Director outlined that the NASC were in the process of getting accredited for same and anticipated that this would be achieved in mid September.

2.2.3 Resignation of Dr Mags Bourke as NASC Medical Educator and MAG Vice-Chair

The Director outlined that at the previous MAG meeting it was agreed that clarification from Mags Bourke would be sought by the PHECC Office as regards to her role on the MAG. He outlined that her role on the MAG was generic from the terms of reference relating to the Medical Educator for the NASC from which she had resigned. He also outlined that her expertise as a Consultant Anaesthetist was a valuable one to the Group and that she had been invited to remain on the Group as an expert Advisor on Anaesthesiology and Paediatric Medicine. Unfortunately this was not feasible for Dr Bourke and hence MAG will need a generic replacement for this role. The Director also outlined that Council will be carrying out a review of Committee memberships over the next number of months, he outlined that this review was timely in view of the broader remit of PHECC at this stage.

The Director also suggested that PHECC correspond to Dr Mags Bourke to thank her for her valuable input and that correspondence would perhaps best come from Council level.

Resolution: MAG recommend to Council that a letter of thanks be forwarded to Dr Mags Bourke on her recent resignation from the MAG for her expert advice and role as Vice Chair of the Group.

Moved: Cathal O'Donnell
Carried without dissent

Seconded: Fergus McCarron

2.2.4 CPG-Ms

The issue of feedback from potential users of the CPG-Ms was discussed. It was agreed that the CPG-Ms should go to MERIT for review.

3. Spinal Immobilisation (EFR)

3.1 Helmet removal

Mr Brian Power outlined that he contacted relevant bodies regarding helmet removal as requested at previous MAG. All the experts agreed that EFRs should remove helmets – as outlined in the meeting papers. MAG agreed to leave helmet removal on the EFR CPGs.

3.2 Extrication

Discussion ensued on the issue of EFR – extrication i.e. with specific correspondence from the Fire Services as included in the meeting papers.

It was agreed to amend the CPG of spinal immobilisation to ensure that rapid extrication be allowed at that level. A proposed wording was included on the CPGs.

Following discussion members agreed to send suggested amendments of the wording to the Chair via Brian Power in PHECC. The Chair would then decide on the final wording.

4. Withdrawal of Lorazepam

As outlined in the meeting papers the issue of refrigeration of lorazepam was problematic with some ambulance vehicles.

It was agreed to leave in Lorazepam if refrigeration is available otherwise change CPG to use diazepam IV or Midazolam (once on the Medication schedule and formulary).

Resolution: That the MAG recommend to Council that CPG-A 11 Version 2 and CPG-A 57 Version 3 be published.

Moved: David Janes
Carried without dissent

Seconded: Gerry Bury

Gerry Bury raised the issues of age of paediatrics and dosages of morphine and other drugs – these issues need to be highlighted to management and frontline staff of all ambulance services.

Brian Power assured members that Naloxone is included on the next edition of the Inadequate respirations for Paediatrics CPGs.

5. Batch 11 CPG for information

Brian Power outlined that the Batch 11 CPGs were included for comments from members before the delphi process.

6. CPG Review

6.1 Spinal Immobilisation – Paediatric <13 years

At the last meeting concerns were raised about this CPG and Brian Power sought feedback from Cathal O'Donnell and Richard Lynch. Discussion ensued on the CPG and the algorithm of Canadian C-spine which had never been validated in paediatric research. Brian Power agreed to redraft this CPG and table at the continuing MAG meeting tomorrow 31st August 2007.

**Draft Meeting Report of the PHECC Medical Advisory Group held at the
PHECC office Naas on Friday 31st August 2007**

Friday 31st August 09:30 – 16:30 hrs

Present:

Mark Doyle
Gerry Bury
Sean Creamer
Conor Egleston
Macartan Hughes
David Janes
Lawrence Kenna
Richard Lynch
Fergus McCarron
Vincent O'Connor
Cathal O'Donnell
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies:

John Burton
Stephen Cusack
Fergal Hickey
Geoff Keye
Declan Lonergan
Peter O'Connor
John O'Donnell
Danny O'Regan
Paul Robinson
Julie Woods
Kevin Flannery

In attendance:

Geoff King
Sharon Gallagher
Brian Power

6.1 CPG Review Spinal Immobilisation – Paediatric

The revised version of the CPG Spinal Immobilisation was distributed, new layout was agreed with the change in the bottom text box reading to "immobilisation may not be indicated" and reverse order of boxes "apply cervical collar" and "life threatening".

Combine helmet removal into one box. It is appropriate to include paramedic and advanced paramedic on the CPG.

"Parents wishes" may need to be mentioned on the sheet. It was felt that this was more appropriate as a generic direction for all CPGs.

Modify adult Spinal Immobilisation CPG similarly.

Resolution: That the Spinal Immobilisation 7a Paediatrics at P & AP, EMT and EFR levels be agreed with the above amendments.

Proposed: Vincent O'Connor
Carried without dissent

Seconded: Fergus McCarron

6.2 Delphi 14

Drowning CPG 22 levels 4, 5 & 6

Change title to submersion incident. Delete red text box “higher pressure may be required for ventilation...”. Remove text boxes “patient is hypovolaemic” and “seizure”. Delete “auscultate chest”. Combine “query c-spine” and “remove horizontally” boxes. Include “if possible” after “remove horizontally”. The “transport to ED etc” box to be highlighted with bold font.

Drowning CPG 22 levels 1, 2 & 3

Change title to submersion incident.
Move up “request AED” and “call for help” text boxes to top of algorithm.
Include changes as agreed above for levels 4,5 & 6 where appropriate.

Hypothermia CPG 23 levels 4, 5 & 6

The importance of being able to measure body temperature accurately in the area of hypothermia was discussed (checking core temperature in pre-hosp environment).

Low reading thermometers are important for rural areas. Core temperature should only be tested if hypothermic and cardiac arrest, and that it should only be carried out by Advanced Paramedics. It was agreed that a new CPG 23 be redrafted and presented to Chair of MAG for ratification.

Hypothermia CPG 23 level 3 EFR

It was agreed to take out the “check and record core temperature” text box and to redraft the CPG as per the previous CPG and to present to the Chair of MAG before being presented for external review.

Decompression illness CPG 24 levels 4, 5 & 6

The issue of including a text box “to notify control to contact hyperbaric unit” was discussed. It was also noted that a second person may be on the same dive- so ideally they should accompany the patient – they may also have symptoms; insert consider “diving buddy” text box.

The inclusion of a side text box was discussed to include “bring dive computer and equipment – consider other divers’ condition”.

The need for a box with clinical pointers was discussed – Prof Bury agreed to develop same to include the history, equipment and other diver key issues.

It was agreed that the altitude text be modified to include “above incident site” after 300 meters.

There was general agreement on this CPG with the inclusion of clinical pointers text box to be developed by Prof Bury.

Decompression illness CPG 24 level 3

It was agreed to remove ECG monitoring text box from this CPG as not relevant for this level. It was agreed that the altitude test be modified to include “above incident site” after 300 meters.

Treat and discharge Medical CPG 25 Level 5 & 6 and Treat and discharge Trauma CPG 25 Level 5 & 6

Discussion ensued on the issue of treat and discharge for medical and trauma incidents. Members discussed the importance of dedicating a full MAG meeting to this issue. Some members disagreed with the inclusion of left hand limb of algorithm (bronchospam). Members agreed that the CPG should be addressed in two strands:

- 1) Treat & Discharge of emergency calls and serious illness/injury – obviously these would be the most controversial to carry out.
- 2) Treat & Discharge of minor illness/injury – these would have the most impact to the health services.

The need to discuss the two strands in the operational and training framework was noted.

David Janes agreed to distribute the current guidelines used by the Advanced Paramedics to all Members.

Mr Cathal O'Donnell noted the important issues were 1) capacity and content and 2) safe discharge and how it would be managed.

Mark Doyle raised the issue of T&D being considered through a research approach. Dr David Janes suggested we limit it to a small number of conditions and publish these and then get follow-up feedback.

It was agreed to delete the left hand limb of the medical algorithm.

The Chair agreed that Treat and Discharge was something that needs to be introduced slowly and carefully.

It was agreed that organisational issues need to be dealt with and hence the services need to be approached for discussion. The Director outlined that PHECC will develop the 2 arms of the algorithm – hypoglycaemia and seizure. There was general agreement.

Resolution: That the Delphi 14 be agreed excluding the “treat and discharge CPGs”.

Proposed: Cathal O'Donnell
Carried without dissent

Seconded: Michael Seaman

6.3 Delphi 15

Secondary Survey CPG 5b – Paediatric P and AP

It was agreed to remove “discharge box” and remove text box “advise guardian to take patient to GP”. Remove “older” from chaperone text box.

Shock from blood loss – Paediatric P and AP CPG A54(i)

It was agreed to delete the red text box “Consider IO if IV not immediately accessible”.

Change the first text box from “hypovolaemia” to “haemorrhagic shock”.

Remove reference to head injury and trauma and have a linear CPG with fluid replacement. Add text box to read - “check radial pulse for older children”.

Septic shock – Paediatric CPG 54 (ii) P and AP

Remove/delete first red text box - “Consider IO if IV not immediately accessible and patient P or U on AVPU scale”.

It was suggested that “cefotaxime 2 boluses – maximum 50 mg/kg infusion or ceftriaxone 2 boluses – maximum 80 mg/kg infusion” be added to the “benzylpenicillin” text box. It was agreed that Brian Power would check with national body on medication for meningococcal disease.

In the third yellow text box edit to read the following:

– “Hartmann’s Solution, 20 mL/kg IV/IO aliquots to maintain palpable brachial pulse or radial pulse for older children.” Change “meningitis suspected” to “meningococcal disease suspected”.

Hypovolaemia – Paediatric CPG A 54 EMT

Title changed to read generic “shock”

Inadequate respirations – Paediatric CPG A 56 P & AP

In the “severe” limb of the algorithm, - delete the “x 1” in the Salbutamol text box.

Move stridor limb into a separate CPG and reverse “humidified O₂” and “do not distress” boxes.

In left hand limb of algorithm Positive Pressure Ventilation text box change “maximum 10 per minute” to “12 to 20 per minute”.

Separate Hx of narcotic and tension pneumothorax into different limbs. Change “tension pneumothorax confirmed” to “suspected”. Include “reassess” after “needle decompression”. Include “naloxone” with AP colour.

Change adult CPG to reflect changes agreed.

Inadequate respirations – Paediatric CPG A 56 EMT

Delete “prescribed salbutamol previously”.

Add in a text box under “Assess and maintain airway” to read – “do not distress. Permit child to adopt position of comfort”.

Add box “consider FBAO – Go to CPG xxx”

Assist patient to administer salbutamol.

Ventilate only unresponsive patients with falling respiratory rate.

Delete “maximum 10 per minute” and add “positive pressure ventilation 12 – 20 respirations per minute.

Inadequate respirations – Paediatric CPG A 56 CFR, OFA & EFR

Change to EFR level only. Add in a text box under “Assess and maintain airway” to read – “do not distress. Permit child to adopt position of comfort”.

Add box “consider FBAO – Go to CPG xxx”

Assist patient to administer salbutamol.

Ventilate only unresponsive patients with falling respiratory rate.

Delete “maximum 10 per minute” and add “positive pressure ventilation 12 – 20 respirations per minute.

Crush Injury – CPG 26 P and AP

Delete “tourniquet” text box. Delete “Salbutamol text box” and “Sodium bicarbonate text box”.

Resolution: That the Delphi 15 be agreed subject to the above amendments.

Proposed: Sean Creamer
Carried without dissent

Seconded: Vincent O’Connor

7. Director’s Update

8. AOB

The issue of how CPGs are managed after external review was discussed. The Director outlined 3 possible systems for final review of CPGs:

- 1) MAG to consider all comments received at regular MAG meetings and deliberate on the findings. MAG to make final decisions and signoff on CPGs.
- 2) Programme Development Officer to consider all comments received and present to MAG issues that require adjudication only. MAG to make final decisions and signoffs on CPGs.
- 3) One medical representative and one pre-hospital emergency care practitioner representative from MAG together with Programme

Development Officer consider all comments received and report to Chair of MAG to present issues that require adjudication only to MAG to make final decisions and signoff on CPGs.

It was agreed that option 3 was most suitable. The Chair agreed to consider the membership of the subgroup.

Mr Brian Power agreed to email the TASER and Head Injury CPGs to all members which will complete the Delphi Process.

It was agreed the next MAG will focus primarily on the CPGs relating to Treat and Discharge.

Signed:

Date:

Mr. Mark Doyle
Chair

Appendix

MAG Discussion on Clinical Practice Guideline Progress Report 2

30th August 2007, Kilashee House Hotel

Present:

Cathal O'Donnell
Michael Seaman
Fergus McCarron
Macartan Hughes
Mark Doyle
Professor Bury
Conor Egleston
David Janes
Vincent O'Connor
Sean Creamer
Martin O'Reilly

In Attendance:

Susan O'Reilly
Geoff King
Brian Power
Sharon Gallagher

CPG Discussion:

The issue of incorporating both AHA & ERC guidance in cardiac CPGs at CFR level was further discussed and it was noted that 8 CFR CPGs are being progressed.

Stroke Services:

MAG to consider the merit of including the Stroke CPG at levels 1, 2 & 3, it was noted that raising awareness of stroke at these levels is extremely important.

Richard Lynch advised that in the Midland area stroke is now the same priority as Cardiac, Mr Mark Doyle raised the need to link into response/dispatch i.e. prioritising dispatch? David Janes suggested that PHECC link with the Midland area Control to assist.

CPG 13b

Mr Mac Hughes suggested to reword to include inaccessible location. It was agreed that PHECC would reword CPG 13b on the issue of pain management and morphine and bring back to MAG.

Symptomatic Bradycardia

Prof Bury suggested to opt for a newer simpler version for two reasons

- In his opinion he is increasingly uneasy about the operationalising of the standards and CPGs. There is a need to challenge the HSE to operationalise these properly.
- There are separate advantages in regards to the education process.

The Director agreed that these were important issues and points of discussion that need to be flagged at Council level and with the HSE.

Ms Susan O'Reilly briefed the group on the recent development of the Research Clearing House at UL followed by extensive discussion.

Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Tuesday 27th November 2007

Present:

Mark Doyle
John Burton
Gerry Bury
Stephen Cusack
Sean Creamer
Macartan Hughes
Lawrence Kenna
Richard Lynch
Cathal O'Donnell
Danny O'Regan
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies:

Paul Robinson
Julie Woods
Conor Egleston
Kevin Flannery
Fergal Hickey
David Janes
Geoff Keye
Declan Lonergan
Peter O'Connor
Vincent O'Connor
John O'Donnell
David McManus
Fergus McCarron

In attendance:

Geoff King
Sharon Gallagher
Brian Power

1. Chair's Business and apologies:

2. Meeting Report and matters arising

2.1 Meeting Report 30th August 2007

Resolution: That the Meeting Report of the MAG, held at the PHECC Office, Naas on the 30th August 2007 be agreed.

Moved: Michael Seaman
Carried without dissent

Seconded: Macartan Hughes

2.2 Matters arising

2.2.1 Withdrawal of Lorazepam

Martin O'Reilly requested that Diazepam IV be added to the Medication Formulary.

He also noted that although individual practitioners and training institutions receive notification of updated CPGs individual service providers had not. The Director outlined that this was an oversight and would be rectified.

Meropenem

Mr Brian Power reported that the drug “Meropenem” for treatment of meningitis for patients allergic to penicillin is used by ED in Our Lady’s Hospital for Sick children, Crumlin.

There was general agreement of the inclusion of Meropenem as a substitute for Benzylpenicillin in the CPGs. Sean Creamer requested storage information on Meropenem to ensure pre-hospital compatibility. Brian agreed to email members with storage information on the drug.

John Burton raised the issue of diazepam and IV flushing. MAG advised that it is OK to flush with all fluids.

3. Treat and Discharge CPGs

The article as distributed in the papers which looked at introduction of non-transport guidelines in the UK was discussed. Cathal O’Donnell suggested that it would be best to have a discussion document summarising key issues such as; assessment; consent, minors, protecting patients; definitions etc...

The Director agreed that PHECC will develop a general document with Cathal’s assistance and bring back to MAG. The Chair suggested that a substantive MAG meeting be conducted to discuss the T&D issue specifically.

4. CPG Review

4.1 Delphi 16 (a)

CPG-Ms – Brian Power outlined that the CPG-Ms were drafted by ISIC to guide the practice of largely General Practitioners in the pre-hospital environment and brought to MAG for ratification.

As agreed at the last meeting MERIT would review the CPG-Ms and recommend a context for training and use. The CPG-Ms are a separate development exercise and not for publication in the 3rd edition of the PHECC Clinical Handbook.

Prof Bury outlined that ISIC/MERIT would like a section in the NQEMT register for Doctors practising e.g. thrombolysis. Discussion ensued on the role of PHECC in ratifying procedures for Doctors and the input from the College of General Practitioners. It was agreed that these would go to

MERIT for discussion and from there a decision would be made on whether to bring to the College of GPs.

Mr Cathal O'Donnell outlined the benefits of such guidelines being agreed through PHECC, enabling consistency of care to the public from Paramedics, Advanced Paramedics and Doctors in the pre-hospital emergency care environment.

CPG-M 10 ACS

It was agreed that a rider be included on the ACS CPG-M outlining that any practice should have discussion/agreement with the local system/service. The following clinical issues were agreed. The issue of GP travelling with the patient is to be decided on a local basis by the GP.

It was agreed that Enoxaparin be used on both limbs instead of Unfractionated Heparin bolus and Enoxaparin.

It was agreed that morphine should be specified as IV in the "MONA" text box.

The CPG-M for the Tenecteplase sections of the algorithm should be the same as the AP ACS CPG.

CPG-M A 3 Tension Pneumothorax (Adult and Paediatric)

Edit top right hand information box to read "Features of Tension pneumothorax and rapid deterioration in pulse RR, SpO₂ etc with no evidence of other ABC cause".

Delete bottom left hand information box "procedural sedation". It was also agreed to remove "Prolonged time to hospital etc" from the algorithm and insert into the information box.

Under left limb – "pt deteriorated" – include – "repeat x 1" (needle thoracentesis).

Change 2nd text box on right hand side to read "assessment and treatment may be carried out during transportation" and move "ambulance" icon/symbol in parallel at side of algorithm.

CPG-M Procedural Sedation - Adult

Discussion ensued on the use of the drug "ketamine" pre-hospital and some reservations were raised especially its use with paediatrics.

Stephen Cusack suggested 1- 3 mg/kg as an appropriate dose. The Chair outlined that the dosages to be checked and reviewed for both midazolam and ketamine and come back to MAG.

It was agreed that the absolute contraindications and cautions need to be separated out in the bottom left hand side text box.

CPG – M Procedural selection Paediatric (<3 months). It was agreed to make the same changes as per adult version, also atropine should be administered routinely.

CPG – M Emergency Sedation – Adult and Paediatric

Agreed

CPG – M 2a Advanced Airway & FBAO Adult

In bottom red text box change “IC Doctors” to “doctors with appropriate training”.

Delete “In Conscious patients, consider procedural sedation / anaesthesia”. It was also agreed that the needle cricothyroidotomy could be included into the AP foreign body airway obstruction CPGs and presented back to MAG for ratification.

CPG – M 2b Advanced Airway & FBAO Paediatric

Surgical airway , it was agreed to remove this term and replace with “cricothyroidotomy”.

In bottom red text box change “IC Doctors” to “doctors with appropriate training”.

Delete “In Conscious patients, consider procedural sedation / anaesthesia”.

It was agreed that the CPG-Ms in present form – from a technical point of view – that MAG approve these to go to MERIT to put in framework for their use.

Resolution: That the Delphi 16 be agreed subject to the above amendments

Proposed: Brendan Whelan
Carried without dissent

Seconded: Cathal O'Donnell

5. Presentation on TASER Gun

Detective Sergeants Terry Brennan and Martin Harrington gave an overview of the Taser weapon which will be introduced into service by the ERU of an Garda Síochána.

They outlined that the Taser is effective within 25 feet of the subject. There are two cartridges, one green and one grey. The green probe covers 25 feet and the grey probe covers 21, tactics and circumstances depend on which cartridge is used.

All of the background research on the weapon, litigation and scientific reports is available on www.taser.com. The tasers have not been deployed yet in Ireland.

The procedure advised is; if it the barbs strike face, eye, groin, or neck, then the barbs are removed in ED. The Garda protocol is that the barbs are removed by trained Garda medics. It was noted that the patient will automatically drop to the ground once hit by the taser. It was noted that if anybody puts their hands between the probes during the activation 5 seconds they will get an electric shock. It was stated that it is unlikely that ambulance personnel therefore will be required to remove the barbs.

Mr Cathal O'Donnell gave some detail on the Taser as per his experience of its use in Toronoto from a medical perspective. He outlined that some issues have arisen in respect of excited delerium, e.g. related to constraint related deaths. The protocol in Toronto involved the transport of all tasered victims to ED for the first two years of its introduction (risk of people experiencing excited delirium and therefore risk of people dying).

Both Detective Sgts. Brennan and Harrington outlined that the Gardai would welcome any medical guidelines in relation to post Taser. Difficulties relating to the circumstances where patients might refuse to go in the ambulance after being tasered were discussed.

Delphi 17

CPG 25 – Conducted Electrical Weapon (Taser) CPG 25

Discussion ensued on TASER CPG 25 and if EFR level should be included in CPG. The following criteria were discussed in relation to a tasered patient being brought to hospital:

- Caridac history
- On psychiatric medications
- Acting bizzarely
- Taking illicit drugs.

The contradictions for removal of barbs to include “eye” and delete “spinal” column” All patients shall be transported to ED following Taser use.

CPG 26 Head Injury Adult

Cathal O'Donnell raised the issue of defining traumatic brain injury.

It was agreed to redirect the "no" limb under GCS \leq 8 to blood glucose. Also to remove the ET CO₂ monitoring text box. Rephrase the red text box to read "Transport to the most appropriate ED according to local protocol. Mark Doyle suggested that it could be introduced as an ideal concept but should be something that is progressive and may need to be revisited.

A concern was raised about the possibility of no cervical collar/ long board being applied if there was no LOC. Replace " Traumatic brain Injury" with "History of loss of consciousness". The issue of defining traumatic brain injury was viewed as a training issue.

CPG 26 Head Injury Adult – EMT level

Discussion ensued on request Paramedic and delayed transport. It was agreed to initiate transport and request help. A concern was raised about the possibility of no cervical collar/ long board being applied if there was no LOC. Replace " Traumatic brain Injury" with "History of loss of consciousness". "Paramedic" higher in the algorithm – below " history of LOC"

Resolution: That the Delphi 17 be agreed subject to the above amendments

Proposed: Cathal O'Donnell
Carried without dissent

Seconded: Michael Seaman

6. AOB

6.1 Decompression illness CPG

Prof Bury outlined a situation recently whereby a diver was unwell and the coast guard intervened and took the patient to a decompression chamber in a non-emergency medical facility. This was a very inappropriate and he urged that the Decompression CPG be published ASAP. Stephen Cusack outlined that the coast guard would normally ring his Dept at Cork UH for advice on same.

Cathal O'Donnell outlined that if the a CPG is published then the Coast Guard personnel will have to follow the CPG at the level they are on the PHECC register.

Stephen Cusack agreed to look into the matter and to come back to MAG on same.

6.2 Prof Bury outlined the C Task score used in Toronto was a credible scale and there was considerable literature available on this scale and that it may be useful to distribute to MAG members for their information. He outlined that it would be useful to see what EDs are using – all medics should be using the same categories i.e. that's why we moved away from CUPS. Brian Power agreed to circulate the Canadian assessment methods to MAG members. – should aim at matching or developing a universal triaging system.

6.3 Prof Bury raised the issue of Paediatric drug dosages and discussion ensued on same. Paeds age ≥ 8 years should not be administered adult doses of morphine or other cardiac drugs. A safety notice should be issued to all AP to read:-
“All medication doses for patients ≤ 13 years shall be calculated on a weight basis unless an age related dose is specified”

6.4 “No naloxone” on CPG for children – need to include in CPG-A for Paeds. Sean Creamer and Mark Doyle (Chairs of CCC and MAG) agreed to sign off Naloxone on CPG and bring to Council. It was agreed that the above go to Clinical Care Committee and Council for ratification but also to flag on the PHECC website.

- 6.5** The issue of Salbutamol repeat timing was tabled by Brian Power. The CPG-P interval is 15 minutes and CPG-As are 20 minutes. There is a need to make both compatible. It was agreed that both would have 15 minute repeat interval and that this could be updated at the next council meeting.
- 6.6** The issue of Epinephrine 1:1,000 limited to pre-filled syringe was discussed. It was pointed out that with the help of Mr. Tom McGuinn (Chief Pharmacist Retired) the next medicinal products schedule would not be as restrictive for this medication.

Resolution: The MAG agreed that Naloxone needs to be available to APs following the administration of morphine to paediatric patients.

Moved: Macartan Hughes

Seconded: Brendan Whelan

Resolution: The MAG agreed that the salbutamol repeat interval be reduced to 15 mins for all CPG-As.

Moved: Lawrence Kenna

Seconded: Gerry Bury

Resolution: The MAG agreed that the calculation for paediatric (≤ 13) medication doses is weight based unless an age related dose is specified.

Moved: Macartan Hughes

Seconded: Danny O'Regan

Signed:

Date:

Mr. Mark Doyle
Chair

**Meeting Report of the PHECC Medical Advisory Group
PHECC Office, Naas. Tuesday 14th February 2006 at 10:00am**

Present: Mark Doyle (Chair)
Sean Creamer
John Burton
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Vincent O'Connor
Cathal O'Donnell
John O'Donnell
Danny O'Regan
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies: Mags Bourke
Stephen Cusack
Conor Egleston
Fergal Hickey
Fergus McCarron
Peter O'Connor
Paul Robinson
Julie Woods

In Attendance: Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Geoff King, Director
Brian Power, Programme Development Officer

1. Chairperson's business:

The Chair advised members that in conjunction with other PHECC Committees and Working Groups, it is intended to fix dates for six MAG meetings per year. The dates will be linked with dates of Clinical Care Committee meetings, i.e. week before the CCC meetings. Member's present indicated Tuesday's as the preferred day for meetings.

2. Meeting Report

Recommendation: That the Meeting Report of the Medical Advisory Group Meeting of 31st August 2005 be agreed.

Moved: Martin O'Reilly
Carried without dissent

Seconded: Lawrence Kenna

3. See item 5 on meeting report

4. Community First Response Report (CFRR)

The draft Patient Care Report for CFR was distributed and members were asked to review and come back with feedback.

5 ILCOR Guidelines 2005

Mr Brian Power distributed an updated matrix on the ILCOR guidelines. Members were asked to review and feedback before the next meeting. The Director outlined that MAG are requested by Council to consider the merit and implications of amending the CPGs / CPG-As as per the new ILCOR Guidelines 2005. Discussion ensued on the alignment of the new American Heart Association Guidelines and the ILCOR Guidelines. The Director agreed that PHECC will redraft the main CPGs and bring back to MAG, members will be requested to review same, taking into consideration the new ILCOR, AHA and ERC guidelines. Changes to CPGs will take place on a phased basis.

CPG 3d – Cardiac Arrest – AED – Child 1 to 8 and CPG-A 51 – Paediatric Ventricular Fibrillation and Pulseless Ventricular Tachycardia were presented for approval following recommendations from MAG meeting 31st August 2005. It was decided not to approve these, but to wait for the new draft to incorporate ILCOR Guidelines 2005.

6 Advanced Paramedic Medications

The Director outlined that PHECC are in consultation with Mr Tom McGuinn, (retired-Chief Pharmacist, DoHC) and his advice regarding Advanced Paramedic Medications will be distributed to members at the next MAG. He also outlined that PHECC will get a formal opinion on licensing (noting "Amiodarone") and refrigeration (noting "Lorazepam") and will bring back to MAG.

6.1 CPG-As

CPG-A 50 – Paediatric Asystole / Pulseless Electrical Activity (PEA)

Discussion ensued on the recommendation from a Cohort 1 member and it was agreed that the decision box on Asystole and reference to atropine be deleted from this CPG-A 50.

The Chair outlined that given the changes delineated and accepting Paediatric Cardiac Arrest algorithm the CPG-As be approved.

CPG-A 9, 10, 54 and 58

Discussion ensued on the recommendations from cohort members and it was agreed they be approved as presented (CPG-A 54 be returned to MAG at a future date for approval).

Recommendation: That CPG-As 9, 10, 50 and 58 be approved given the changes delineated and accepting the Paediatric cardiac arrest algorithm.

Moved: John Burton

Seconded: Cathal O'Donnell

Carried without dissent.

7. CPG review

Major Emergency Terminology

Discussion ensued regarding the use of dual or single terminology for major emergency. It was outlined that MIMMS terminology was accepted by the HeBE and the Cross Border Group. There was general agreement to use MIMMS but PHECC will engage with the Department of the Environment regarding terminology in use by them.

8. CPG development

LUCAS Compression Device

Following discussion it was agreed that any CPG for an automated compression device should be generic. It was also stated that ethical issues may arise in relation to stopping the device.

The Director agreed that PHECC would come back to MAG with two generifed CPGs on above, one specifying BLS and a second one specifying ALS.

9. IV Management Policy

Draft HSE North Western area

The Director distributed a Draft IV Management Policy completed in the North West (with input from PHECC) for information.

10. Development of CPG-Ms

The Director stated that the development of CPG-Ms for use by medical practitioners pre-hospital would take place later this year.

11. Infection Control Guidelines

Avian Influenza

On overview of Avian Flu epizootic disease was distributed and discussed briefly and members were asked to review the document and to consider PHECC's role in developing Infection Control Guidelines. The director agreed PHECC would come back to MAG on this issue as appropriate.

12. Training and Education Standards

12.1 Feedback

A draft document was distributed with a summary of the feedback received from the Draft Training and Education Standards.

12.2 Matrix of Medications and interventions

A Draft matrix document outlining the medicinal products and interventions that may be supplied to and administered by pre-hospital emergency care responders and practitioners according to the draft Standards and the Medicinal Products (prescription and Control of Supply) Amendment Regulations (S.I. 510 of 2005) was distributed for information and review. The members were requested to forward all feedback to the PHECC Office before the next MAG.

13. Services Gateway

Implementation of PCR and ePCR

Ms Jacqueline Egan updated the group on the current status of PCR and ePCR training and rollout, she also informed members that there will be a presentation on both PCR and ePCR development at the next meeting, as well as the PHECC Services Gateway.

14. AOB

The Director outlined that Council (the previous week) approved the 1st 29 Advanced Paramedics, 170 Paramedics and 8 EMTs to the PHECC register. He also informed members that a letter from PHECC will be forwarded to both Paramedics, Advanced Paramedics and EMTs outlining their authorisations to use specific schedules. PHECC will also write to the services/organisations regarding same.

The Chair requested that all Training and Development Officers keep PHECC updated on a regular basis on their employee's status i.e. retired, deceased. In view of the development of the PHECC register some families have received letters re the register for their deceased family members. In order to avoid this in the future the Chair requested that the T&Ds notify PHECC when an employee's status changes.

Date of next MAG meeting to be decided.

Signed:

Date:

**Mr. Mark Doyle,
Chair**

**Meeting Report of the PHECC Medical Advisory Group
PHECC Office, Naas. Tuesday 28th March 2006 at 10:30am**

Present: Mark Doyle (Chair)
Gerry Bury
Sean Creamer
John Burton
Macartan Hughes
Richard Lynch
Lawrence Kenna
Declan Lonergan
Martin O'Reilly
Michael Seaman

Apologies: Mags Bourke
Stephen Cusack
Conor Egleston
Fergal Hickey
Fergus McCarron
Vincent O'Connor
Cathal O'Donnell
John O'Donnell
Danny O'Regan
Peter O'Connor
Paul Robinson
Brendan Whelan
Julie Woods

In Attendance: Pauline Dempsey, Programme Development Officer
Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Geoff King, Director
Brian Power, Programme Development Officer

1. Chairperson's business:

2. Meeting Report

**Resolution : That the Meeting Report of the Medical Advisory Group
Meeting of 14th February 2006 be agreed.**

Moved: Michael Seaman
Carried without dissent

Seconded: Sean Creamer

3. CPG Review

3.1 Third edition

Mr Brian Power discussed the first draft of the 3rd Edition of the CPGs incorporating the current ILCOR guidelines.

The Director outlined that the plan is to introduce to MAG new concepts regarding the revision of CPGs:

- Incorporating ILCOR Guidelines
- Medication Formulary rather than medication CPGs
- Citizen algorithms
- Different levels of clinical practice
- Common standard for communication centre advice
- Concept of discharging patients

The Director requested feedback from members both in terms of structure, layout, levels, colour codes and content. It was outlined to the group that regarding CPG presentation formats – consideration should be given to the trainers having an aggregated manual and each pre-hospital emergency care practitioner having a CPG manual appropriate to their level. It was also suggested that where possible the CPG should be given a text name and not just a number, i.e. Foreign Body Airway Obstruction. It was also agreed that a reference key was needed to summarise the colours and symbols in use in the CPGs.

Discussion ensued regarding the use of either AHA or ERC guidelines or both as the main reference for the CPGs and it was agreed that MAG need to guide this issue. There was general agreement to use ILCOR guidelines for the CPGs as an umbrella guide.

The issue of professional registration North and South, and differences in guidelines/training was also discussed. It was noted that a professional framework was needed to cover the new legal framework for practice cross border. The Director agreed to review the EU directive 93/16 which deals with regulations cross borders and come back to MAG as appropriate.

The Director outlined that at the next MAG it was anticipated to present the first draft of the BLS guidelines incorporating the ILCOR guidelines for consideration by members.

Following discussion on the immediate need to update certain CPGs the Director agreed to draft a letter (which will be approved by the Chair) outlining the following amendments be prepared:

- Ratios of chest compressions and ventilations change to 30:2 for single rescuer for all ages except neonates

- A ratio of 15:2 chest compressions to ventilations for two rescuer CPR for child and infant for healthcare practitioners only
- Single shocks sequence on all AEDs

This letter will be presented to Council and corresponded to all T&Ds, Training Institutions, Services - statutory, voluntary and auxillary.

Discussion also took place regarding the following:

- AEDs and the functionality of the various devices especially the "switching on" manual function.
- Concept of patient discharge was accepted but a CPG was required for same and to include removing IVs lines etc.

The Director asked the group to give feedback to MAG on patient discharge. It was suggested that an independent expert review the third edition CPGs prior to publication.

Prof Bury complimented Mr Brian Power on producing such high standard guidelines, and suggested that PHECC should seek copyright as soon as they are complete.

4. ILCOR Guidelines 2005

Discussed as item 3 above.

5. Medications

5.1 Morphine licences

The Director informed members that both HSE and DFB ambulance services had submitted their application for a morphine licence.

Licensing of medications

The Director outlined that the relevance of licencing of drugs will be best exemplified on review of CPGs.

Amiodarone and Diazepam for paediatrics will be looked at specifically and details will be brought back to MAG.

Mr Richard Lynch agreed to query the above with the Pharmacist in the Midland area and subsequently inform PHECC Office.

The Director also agreed to engage with Tom McGuinn for more information and return to MAG.

6. Infection Control Guidelines

6.1 Avian Flu

Discussion ensued regarding the role of PHECC in the preparation of Avian flu procedures. Ms Jacqueline Egan distributed the following document as published by the HPSC - "algorithm for the management of persons with acute febrile respiratory illness who may have avian influenza" and she outlined that these algorithms are revised frequently. It was suggested following discussion that broad CPGs on general infection control measures be developed by PHECC with the possibility of including "add ons" or references for specific viruses or illnesses (i.e. in the clinical procedures section at back of clinical handbook) . The Director agreed to come back to MAG on same.

7. Training and Education Standards

Update

The Director updated members on current situation regarding feedback on the standards from both training institutions and he appealed for members to provide feedback.

8. Services Gateway

Update

Mr Barry O'Sullivan presented to members on the current developments of the Services Information Gateway.

9. AOB

9.1

CPG-A 4 Adult Anaphylaxis and CPG-A 55 Paediatric Anaphylaxis were distributed to members as it had been flagged by Dr Mags Bourke on correspondence to the PHECC Office as in need of amending. The following amendment was agreed under the "mild" heading (flow chart section) to: delete "reoccurs" from the diamond text box so that box would only read "deteriorates". It was considered prudent to reissue the updated CPG-As4 & 55 to the training institutions, to all advanced paramedic graduates and students.

It was also agreed to present the revised CPG-As 4 & 55 to Dr Mags Bourke for her approval.

Recommendation: That CPG-A 4 & 55 be approved with above amendment following approval by Dr. Mags Bourke and Clinical Care Committee.

Moved: Michael Seaman
Carried without dissent

Seconded: Declan Lonergan

9.2

The Director updated members on the numbers already signed up to the Register, currently rising to over 300.

9.3.

Mr Richard Lynch spoke regarding the clinical placement supervision of advanced paramedics in the Midland area and volunteered his services in a supervisory role for one advanced paramedic initially. Both the Director and Prof Bury (NATS/UCD) acknowledged this offer.

9.4

A question was posed in relation to the resuscitation of a patient whilst being transported home by an EMT/Paramedic from a hospital/hospice to die. The CPGs currently do not permit withholding of resuscitation in such circumstances. The Director agreed to come back to MAG on the issue.

9.5

The following paper on the LUCAS device was distributed to members for their information. "Active compression-decompression CPR necessitates follow-up post mortem".

Date of next MAG meeting was rescheduled to the 30th May 10.30am in the PHECC Office.

Signed:

Date:

**Mr. Mark Doyle,
Chair**

**Meeting Report of the PHECC Medical Advisory Group
PHECC Office, Naas. Tuesday 30th May 2006 at 10:30am**

Present: Mark Doyle (Chair)
Gerry Bury
John Burton
Conor Egleston
Lawrence Kenna
Geoff Keye
Declan Lonergan
Cathal O'Donnell
Danny O'Regan
Martin O'Reilly
Fergus McCarron
Brendan Whelan
Paul Robinson

Apologies: Mags Bourke
Sean Creamer
Stephen Cusack
Macartan Hughes
Richard Lynch
Fergal Hickey
Vincent O'Connor
John O'Donnell
Peter O'Connor
Michael Seaman
Julie Woods

In Attendance: Jacqueline Egan
Sharon Gallagher
Geoff King
Brian Power

- 1. Chairperson's business:**
- 2. Meeting Report and Matters Arising**

2.1 Meeting Report

**Resolution : That the Meeting Report of the Medical Advisory Group
Meeting of 28th March 2006 be agreed.**

Moved: Declan Lonergan
Carried without dissent

Seconded: Fergus McCarron

2.2 Matters arising

The Director outlined that Morphine Licences had been issued to the HSE and to DFB. The issue of DNR orders was discussed. The Director undertook to brief MAG on the background and current situation regarding DNR orders at a future meeting.

3. CPG Review

CPG-A 4 Anaphylaxis Adult & CPG-A 55 Anaphylaxis Paediatric

Both CPG-As were amended following correspondence with Dr Mags Bourke and presented for approval.

Recommendation: That CPG-A 4 & 55 be approved and recommended to Clinical Care Committee for ratification.

Moved: Connor Egleston
Carried without dissent

Seconded: Danny O'Regan

3.1.1 The revised ILCOR guidelines and draft letter regarding same as distributed in the meeting papers were discussed. The following addition was agreed to be included on the correspondence letter after point 3; "To this affect PHECC recommends 2.1 should be norm for resuscitation training after 1st July 2006. 2.2 and 2.3 should be adopted and implemented." Members agreed that the letter with amendments should be distributed to all the Services - statutory, voluntary and auxiliary and accredited training institutions.

3.1.2 A discussion ensued on the issue of specifications of different types of defibrillators and it was agreed that PHECC would write to the HSE and the MERIT Project regarding development of generic specifications for defibrillators.

3.2 Third edition

Mr Brian Power distributed a document on the Medical Advisory Group CPG adoption process for approval; outlining the following six points:

- 1 CPGs shall be drafted initially by PHECC Programme Development Officer.
- 2 A batch of draft CPGs shall be sent to MAG members at least one week prior to a MAG meeting.
- 3 Each draft CPG shall go through two MAG meetings prior to receiving interim approval.
- 4 When all 3rd Edition CPGs receive interim approval the CPGs shall be reviewed by an external expert(s).
- 5 MAG shall debate the recommendations (if any) from the expert(s).
- 6 MAG shall recommend publication of 3rd Edition CPGs to the Clinical Care Committee.

There was agreement in principle on the proposal process and it would be distributed to all MAG members for comments. It was agreed that PHECC Office will explore a means of getting sign off by all members and bring back to MAG.

Mr Brian Power discussed the feedback received from the first draft of the 3rd Edition of the CPGs as distributed in the meeting papers.

CPGs Batch Two:

CPG 3a - VF or Pulseless VT Adult Basic & Advanced Life Support

Following discussion the first two boxes highlighting MAG decision were agreed. In the third box however it was agreed in the interim to amend to read "Transport decision - consider 6 shocks or if no ALS available <20 minutes."

It was suggested that a follow up in the clinical and basic scientific research literature on the effectiveness of the 7th and subsequent shocks be completed to inform MAG.

CPG 4a – Primary Survey Trauma - Paediatric

It was agreed to move the text boxes relevant to "spinal injury" above text box "Sick child". It was also agreed to remove the word "consider" from the "Oxygen therapy" text box.

In the ventilations (breaths) text box – it was agreed to amend to read as follows "Give 2 effective ventilations (up to 5 attempts)"

CPG 4a – Primary Survey Medical - Paediatric

It was agreed to remove the word "consider" from the "Oxygen therapy" text box. In the ventilations (breaths) text box – it was agreed to amend to read as follows "Give 2 effective ventilations (up to 5 attempts)"

It was agreed to include a decision box for patients <1 year with pulse >60.

CPG 10 – Acute Coronary Syndrome

It was agreed for Level 1 and 2 to make the first text box more specific to read "Chest Pain / suspected heart attack".

For level 5 and 6 it was agreed to remove "troponin test".

A discussion ensued on the issues of availability of PCI in different regions and how this availability would differ in each urban and rural area. It was agreed to change "relative contraindications" to "absolute contraindications". JRCALC contraindications to be considered for comparison.

CPG 13b - Pain Management Paediatrics

It was agreed to raise the initial dosage of morphine to 0.05 mg/kg and 2 subsequent aliquots of 0.025 mg/kg up to maximum of 0.1 mg/kg.

CPG 13b - Pain Management Adult

It was suggested that an extra column be inserted to reflect analgesia for musculoskeletal pain. An extra column would be drafted and presented to MAG.

CPG-A 11 - Seizure/convulsions Adult Level 5 and 6

Lorazepam and its requirement for refrigeration was discussed. It was agreed to leave Lorazepam on the CPG but to give option for diazemuls or diazepam. It was agreed to develop and consider treat and discharge criteria for this and other relevant CPGs.

CPG-A 57 - Seizure/convulsions Paediatric – Level 2 to 4

It was agreed to change “Oropharyngeal airway” to read “Airway Management”. It was agreed that Level 4 can administer glucagon.

CPG-A 57 - Seizure/convulsions Paediatric – Level 5 & 6

Discussion as per CPG-A 11 regarding refrigeration, diazemuls and diazepam.

3.3 CPGs Batch One

CPG 1a – BLS – Adult

It was agreed that BLS Adult CPG should have three categories; citizen, levels 1 to 3 and levels 4 to 6. It was also agreed to remove the “ABCs” from CPG 1a for levels 4 to 6 as it is in primary survey.

CPG 1b – BLS - Child

It was agreed that BLS Child CPG should have three categories; citizen, levels 1 to 3 and levels 4 to 6. It was also agreed to remove the “ABCs” from CPG 1a for levels 4 to 6 as it is in primary survey. It was agreed to remove the word “consider “ for oxygen. In the ventilations (breaths) text box – it was agreed to amend to read as follows “Give 2 effective ventilations (up to 5 attempts)”.

It was agreed to adopt the ILCOR Guideline in relation to paediatric defibrillation energy, i.e. 2J/Kg for initial shock then 4J/kg for subsequent shocks.

CPG 1c – BLS &ALS - Infant

It was agreed that BLS Infant CPG should have three categories; citizen, levels 1 to 3 and levels 4 to 6. It was also agreed to remove the “ABCs” from CPG 1a for levels 4 to 6 as it is in primary survey.

CPG 1d – BLS & ALS Neonate

Take out “ALS at scene <10min”. It was agreed that 10 mL/kg would be the dose for Hartmann’s Solution and 0.01 mg/kg the dose for Epinephrine.

CPG 2a – FBAO Adult

Laryngoscopy and Magill forceps for obstructed airway for Level 5 was not approved.

CPG 2b - FBAO Paediatric

“Attempt to remove” instead of “finger sweep”. The term use of effective communication to an infant <1 was questioned. It was agreed not to discharge paediatric patient post FBAO episode.

CPG 3a - Cardiac Arrest Asystole – Adult

Asystolic arrest for levels 5 and 6. It was agreed to use term “mechanical CPR assist” to describe all mechanical CPR devices. Agreed dose of 3 mg Atropine (single dose).

CPG 3a - Cardiac Arrest PEA – Adult

It was agreed that Atropine would be administered in 1 mg doses up to a maximum of 3 mg.

CPG 3d - Cardiac Arrest AED Child

It was agreed that level 4 could use AED on child. IO agreed as primary circulation route for arrested children if no IV in place (level 6 only).

“ALS <10 minute” – agreed to remove

Definition of child – change Paediatric age to “1 year to puberty”. Medications for Advanced Paramedics may have to be changed to weight based. It was agreed that the issue of age groups would be further considered by MAG. Consider transport after 6 shocks for level 5 and 6.

CPG 4a – Primary Survey Trauma Child

Take out “consider” for oxygen.

CPG 4a - Adult medical

A discussion took place on NPA level 4. It was agreed to leave at level 5 currently.

CPG 4a Primary Survey Trauma – adult level 3-6.

Jaw thrust for level 4.

CPG 13e – Glycaemic Emergency Adult

As agreed in CPG-A 57 Glucagon permitted at level 4 but not at level 3.

“ALS <10 minutes at scene” – take out if level 4

At level 5 and 6 if blood sugar > 4 <15 mmol/L patient may be discharged and at level 3 & 4 if blood sugar >4 <10 mmol/L and patient is alert.

CPG 13e - Glycaemic Emergency Paediatric

Remove glucose gel in level 5 & 6, use glucagon. Dextrose 10% 5 mL/kg is the agreed dose.

CPG 13e - Glycaemic Emergency Paediatric

Level 3 & 4; Glucagon agreed for level 4 only.

Batch One

The following CPGs were reviewed and no changes recommended;
CPG 1b&1c BLS Child and infant - citizen,
CPG 1a BLS – adult – citizen,
CPG 1d BLS neonate – level 4,
CPG 3c recognition of death – resuscitation not indicated – level 5 & 6.

Batch Two

The following CPGs were reviewed and no changes recommended:
CPG-A 11 seizures/convulsions – adult level 2-4.

4. Skills Review – Carried over to next MAG agenda

**5. Advanced Paramedic - Carried over to next MAG agenda
- Medical Oversight**

6. AOB

Cathal O'Donnell presented a laryngeal tube that is currently being trialled in Ireland. The Chair outlined that MAG or PHECC do not have a function or responsibility to trial new equipment. Mr O'Donnell outlined that he would be willing to put his views on the device in a document and present to MAG.

Signed:

Date:

**Mr. Mark Doyle,
Chair**

**Meeting Report of the PHECC Medical Advisory Group
PHECC Office, Naas. Tuesday 29th August 2006 at 10:30am**

Present: Mark Doyle (Chair)
Gerry Bury
Macartan Hughes
David Janes
Lawrence Kenna
Declan Lonergan
Richard Lynch
Cathal O'Donnell
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies: Sean Creamer
Stephen Cusack
Conor Egleston
Geoff Keye
Fergal Hickey
Vincent O'Connor
John O'Donnell
Danny O'Regan
Fergus McCarron
Paul Robinson
Julie Woods

In Attendance: Jacqueline Egan
Sharon Gallagher
Geoff King
Brian Power

1. Chairperson's business:

The Chair welcomed Dr David Janes to the MAG meeting, as a representative of NATS/UCD.

2. Meeting Report and Matters Arising

The following amendment to the March meeting report was agreed; the definition of "Paediatric" for AED use only remains as "1-8 years", otherwise the

definition of Paediatric is “1- puberty”. It was also agreed that the age span i.e. (1-puberty / 1 - 8years) should be specified and inserted in the title in brackets for all Paediatric CPGs.

2.1 Meeting Report

Resolution: That the Meeting Report of the Medical Advisory Group with the inclusion of the above amendment of 30th May 2006 be agreed.

Moved: Macartan Hughes

Seconded: Michael Seaman

Carried without dissent

3.0 CPG Review

It was agreed that appropriate references should be included on each CPG (e.g. ILCOR 2005 Guidelines) and in a bibliography.

3.1.1 Delphi Process

The Chair gave a brief overview of the Delphi Process and outlined the importance of it for accountability. It was agreed that the CPGs will be distributed to members under the delphi process in batches of 8 with a fortnight return time, following which the next batch of 8 will be forwarded to members. It was hence agreed to change the wording on the delphi document as follows:

- delete “3 weeks“ on point 2
- delete prior to MAG meeting and and insert “2 weeks”

Resolution: That the Delphi Process be approved with the above amendments.

Moved: Cathal O’Donnell

Seconded: Macartan Hughes

Carried without dissent

3.1.2 Delphi Sp CPGs

Mr Brian Power distributed the Delphi Feedback document (the compilation and sum of scores with comments from individuals) and each CPG was discussed as follows:

CPG 1A It was agreed to move box “Call 999” up to directly follow “unresponsive” . It was also agreed to insert a text box at corner of CPG to read as follow: “if you have not been trained in Cardiopulmonary Resuscitation

(CPR) follow this protocol, if you have been trained in CPR follow your training protocol”.

CPG 1b & 1c It was agreed to use visuals/diagrams for 1b and 1c - small child (baby from 6 months to 3 or 4 year old).

Depth of chest compressions and evidence on compression only CPR was also discussed, it was agreed that this issue would be returned to MAG with further evidence.

CPG 1d The following amendment was agreed – Use term “positive pressure ventilations (PPV)” instead of “rescue breaths” for 30 seconds.

CPG P1 Paramedic

It was agreed to use the term “CO₂ detector device” instead of capnography. It was agreed to discuss the evidence on laryngeal tube and BVM at next MAG.

CPG P3 Inadequate Respirations – Adult

It was agreed to start the algorithm at “Symptom complex” then to, “Respiratory Distress suggestive of bronchospasm” then to “Salbutamol administration”.

It was suggested to divide algorithm into 2 limbs (i.e. severe, moderate) peak-flow to be taught as part of the procedure but not mentioned on CPG.

SpO₂ should also be checked.

It was agreed to put P3 and E3 as one.

Members agreed that EMTs should be allowed to administer Salbutamol.

Resolution: That CPG 1a, 1b & 1c, 1d and CPG P1 - be agreed by MAG

Moved: Michael Seaman

Seconded: David Janes

Carried without dissent

The Chair requested that members contact Brian Power in the PHECC office with any specific issues relating to CPGs if possible before the DELPHI process is underway.

3.2 CPGs Batches 2 &3

Fifty one CPGs for the third Edition of the Clinical handbook were included in the meeting papers with those flagged below for issues to be approved by MAG:

CPG 1a EMT/ P / AP

Compression only CPR was raised for agreement, it was decided to adhere to the ILCOR guidelines(i.e. 30 compressions: 2 ventilations) for the interim until further research available.

It was agreed that MAG were not in a position to make a decision on the use of Impedance Threshold Device (ITD) during initial CPR until further evidence was available.

CPG 1C Basic and Advanced Life Support – Infant EMT / P / AP

The issue of paediatric intubation for Advanced Paramedic was discussed and it was agreed by MAG to be an appropriate procedure for Advanced Paramedics.

CPG 3c Recognition of Death - Resuscitation not indicated – EMT / P / AP

The Director asked members to take note of the wording on 3c (end stage of terminal illness, reliable written or verbal information from family); this aspect was agreed as warranting further discussion.

CPG 3d Cardiac Arrest AED – Child

Paediatric intubation for Advanced Paramedic was agreed as per 1c.

CPG 4a Primary Survey Medical – Adult EFR/EMT/P/AP

It was agreed that practitioners could consider the administration of O₂ therapy for patients depending on clinical assessment.

CPG 10 Acute Coronary Syndrome

Indications and contraindications for thrombolysis on CPG as checklist.

Consent form to be developed for patients, this form will require patient's signature.

Agreed that >75 goes to contraindications for thrombolysis. Include symptoms duration over 12 hours – as contraindications. Include systolic BP >180 in contraindications. Include aortic dissection in contraindications.

Delete heart rate from contraindications.

Discussion ensued on the use of fibrinolytics – PHECC to return to MAG with information as appropriate.

CPG-A 11 Seizure/convulsions Adult OFA, EFR EMT

It was agreed that it was not appropriate for Paracetamol PO/PR to be administered for a febrile adult.

CPG-A 11 Seizure/convulsions Adult P/AP

It was agreed that it was not appropriate for Paracetamol PO/PR to be administered to a febrile adult. It was agreed that diazepam 5-10 mg was a

more suitable dose and PHECC agreed to come back to MAG as appropriate with detailed evidence on Midazolam buccal and IM. Lorazepam IM shelf life was identified as a difficulty particularly if not refrigerated.

CPG-A 57 Seizure/convulsion Paediatric P/AP

It was agreed that diazepam be administered at 0.2mg/kg IV and Midazolam at 0.5 mg/kg buccal.

CPG - 3b Cardiac arrest Asystole

It was agreed that “resuscitation should be continuous for at least 20 mins” prior to ceasing resuscitation. It was also agreed to leave as <18 years and not <14 years for contraindications for ceasing resuscitation.

CPG 7a Spinal Immobilisation Adult P /AP

It was agreed that it was appropriate for Paramedics to make decision on spinal immobilisation of patient.

CPG 9b Umbilical Cord Complications P / AP

The Director agreed to supply evidence on Nifedipine to delay labour.

CPG A 3 Inadequate Respirations – Adult P /AP

Discussion ensued on the use of Epinephrine and it was suggested to research administration of Magnesium (2 g IV every 5 mins) and come back with evidence to MAG when appropriate.

PHECC also agreed to come back to MAG with more evidence on GTN for CCF.

It was agreed that Frusemide was appropriate for CCF.

The use of Naloxone was agreed for Paramedic level at dose of 0.4 mg IM, repeat by 1 if not effective or no response.

Urinary catheterisation was inappropriate for this CPG.

4. Director’s update

The Director briefed members on the following areas as per included in the meeting papers

- Major Emergency Terminology
- Unlicensed Medications
- DNR Orders
- GPs and CPGs

5. Standards

The Director updated members on the Medications, skills/procedures as per level of training and division on Register as per included in the meeting papers. He sought advice from members on ILCOR Guidelines implementation and CFR/Instructor implementation in the services.

6. Continuous Professional Development (CPD)

The Director outlined the upskilling required for Paramedics as a result of the new standards. It is proposed to include the upskilling as part of CPD starting with LMA insertion and salbutamol administration.

7. Medical Oversight

It was outlined that Medical Oversight was an important issue in pre-hospital care and the Chair requested members to commit their ideas to PHECC for discussion. The Director proposed to raise the issue with Council and consequently develop the concept / model on same.

8. AIDE Memoires

The Director asked members for direction regarding preference for slide rule model or tape model.

The Chair requested members to contact Brian Power in PHECC office with opinions on same before next MAG in order for a format to be developed.

9. AOB

The Chair outlined that due to the nature of developing the 3rd Edition of the Clinical Handbook, there is a requirement for the MAG meeting to be extended to a full day meeting or to be held more frequently. It was agreed by the group that future meetings should be extended to one day and approval for 15 CPGs be sought per meeting.

Signed:

Date:

Mr. Mark Doyle,

Chair

**Meeting Report of the PHECC Medical Advisory Group
PHECC Office, Naas. Tuesday 10th October 2006 at 10:30am**

Present: Mark Doyle (Chair)
Lawrence Kenna
Geoff Keye
Declan Lonergan
Martin O'Reilly
Michael Seaman
Brendan Whelan

Apologies: Gerry Bury
Sean Creamer
Stephen Cusack
Conor Egleston
Macartan Hughes
David Janes
Fergal Hickey
Richard Lynch
Vincent O'Connor
Cathal O'Donnell
John O'Donnell
Danny O'Regan
Fergus McCarron
Paul Robinson
Julie Woods

In Attendance: Jacqueline Egan
Sharon Gallagher
Geoff King
Brian Power

- 1. Chairperson's business:**

- 2. Meeting Report and Matters Arising**

The following amendment to the August meeting report was agreed; Page 5, CPG 3b Cardiac Arrest Asystole – the wording on the first sentence in this paragraph to be amended, delete “it was agreed that” and replace with the following:

The issue regarding “resuscitation should be continuous for at least 20 mins prior to ceasing resuscitation” would be further discussed.

2.1 Meeting Report

Resolution: That the Meeting Report of the Medical Advisory Group with the inclusion of the above amendment of 29th August 2006 be agreed.

Moved: Declan Lonergan

Seconded: Lawrence Kenna

Carried without dissent

2.2 Matters arising

The Director informed the group that work in the PHECC office was ongoing regarding licencing matters and schedule for additional medicines. He also noted that no feedback had been received since the last MAG regarding the Aide Memoire for paediatric dosages. The Chair stated that all members had agreed that it would be an extremely useful device for advanced paramedics and it was agreed that this subject would be brought to the next MAG meeting following consultations with the advanced paramedics on the PHECC register.

3.0 CPG Review

3.1.1 Delphi Process 2

Mr Brian Power distributed the Delphi 2 Feedback document (the compilation and sum of scores with comments from individuals) and each CPG was discussed as follows:

Eight CPGs for Delphi process 2 had been distributed to members.

CPG 4a – Primary Survey Trauma Adult – L3 to 6

It was agreed that ‘practitioner’ level and ‘responder’ level should not be on the same CPG.

It was also agreed to put “ jaw thrust” first (primary manoeuvre) and then “head tilt” in brackets in the “head tilt/chin lift” text box.

It was stated that the ‘adequate ventilations’ diamond was causing difficulties with flow through the CPG. It was also stated that ‘Signs of Circulation’ was no longer a term to use.

CPG 4a Primary Survey Medical Adult – L3 to 6

It was agreed to adopt same changes as agreed in Primary Survey Trauma Adult with the exception of ‘jaw thrust’.

CPG 4b – Primary Survey Trauma – Paediatric

It was agreed to take out the “sick child” decision for EMFR and EMT levels, and leave for Paramedic and Advanced Paramedic levels.

A box indicating that primary survey findings were confirmed is to be included prior to CUPS for non sick child.

The age will be included for all paediatric CPGs. It was also agreed that pulse >60 box should be included for this CPG.

CPG 4b Primary Survey Medical – Paediatric L3 - 6

It was agreed that “sick child” be dealt with as outlined in Primary Survey Trauma – Paediatric.

Other changes to reflect proposals for Primary Survey Trauma - Paediatric.

CPG 1a – Basic Life Support – Adult; L1 to 3

It was agreed to change the wording in text box from “assess rhythm” to “analyse rhythm”. Remove text “Continue until Paramedic, Advanced Paramedic etc” and place into a separate box.

CPG 1b – Basic Life Support – Child; L1 to 3

A discussion took place on Paediatric AED use for this level and it was agreed to come back to MAG having sought the opinion of all MAG members on the issue.

CPG 1c – Basic Life Support – Infant

It was agreed to amalgamate CPGs 1b and 1c (BLS child and infant). Child age range from 6 weeks to 8 years and adult range 8 years upwards was agreed for this CPG.

CPG P3 – Inadequate Respirations – Adult

It was agreed to commence the algorithm at “bronchospasm assessment” and remove “expiratory wheeze” from the algorithm.

It was agreed to include “mild” in the text box under Bronchospasm assessment.

The issue of the use of inhaler and nebuliser at varying levels was discussed. The use of nebuliser for administration of salbutamol was agreed following on from the text box “Moderate”. It was also agreed that nebuliser or aerosol was an option for moderate bronchospasm. It was agreed to link mild text box to aerosol salbutamol and treat and discharge. An SpO₂ monitor to be included in algorithm.

General Comment

A general discussion ensued on the use of the term CUPS in pre-hospital practice, the question was raised as to whether another better known and common triage term be used rather than CUPS in the PHECC CPGs. There was general agreement on the need to describe some level of urgency in alternative terms and for it to be linked to the PHECC standards, e.g. Manchester or Australian Triage System. It was agreed by the Director to look at alternatives and bring back to MAG and it was also agreed to take CUPS out of PCR if it was discontinued.

Resolution: That the Batch 2 Delphi CPGs be approved at this stage for development with the above amendments.

Moved: Geoff Keye

Seconded: Michael Seaman

Carried without dissent

3.1.2 Delphi Process 3

Mr Brian Power distributed the Delphi 3 Feedback document (the compilation and sum of scores with comments from individuals) and each CPG was discussed as follows:

CPG 3a – VF or Pulseless VT – Adult

It was agreed to remove advisory box on epinephrine via ETT. Also it was agreed to remove advisory box on “re-entry of algorithm VF or Pulseless VT. In advisory box regarding persistent VF/VT it was agreed to include maximum 20 mins on scene. Discussion ensued on use of Magnesium and it was agreed that it remain on the CPG. The use of the Laryngeal tube was questioned in the Delphi process, however the members were not present to present their cases. It was agreed that the MAG Chairman would consult with the key players both for and against and return with a consensus.

It was agreed to include one epinephrine only on the algorithm and include “every 3 to 5 minutes if appropriate”. It was also agreed to place medications in parallel with CPR boxes.

It was agreed that remaining information boxes be moved to opposite page in the formatting of the final version of CPGs.

Discussion ensued regarding IO instead of ETT on adults and Dr Geoff Keyes stated that consideration should be given to introduce IO access in adults for

advanced paramedics if vascular access not possible in arrest or peri arrest situations. The Chair stipulated that all members of the MAG group should be corresponded with regarding same – and a decision made following feedback being received on the following questions:

- Do you agree to IO Access being used in cardiac arrest if IV access not available?
- Can IO be used as an alternative in adults if no IV access available for hypovolaemia?

It was also noted that this would effect the Education and Training Standard. There was extensive discussion regarding the position of EMTs transporting patients on this algorithm. It was agreed for the interim to remove the restriction on the EMTs transporting. The Chair suggested that it was time to give consideration to the appropriate tasking of different levels on the PHECC register for specific emergency conditions. It was agreed that EMT was not the appropriate level for primary care givers on an emergency ambulance and that at least one paramedic should form part of the crew.

It was also agreed by MAG that the issue of crewing of emergency ambulances be forwarded to Clinical Care and take back to MAG as appropriate.

Advisory box on Epinephrine to change as agreed with CPG 3a. The possible causes of cardiac arrest to include “trauma”, also change “tablets” to “toxins”. It was agreed that the causes box be included on all cardiac arrest algorithms.

CPG 3a (i) – Cardiac Arrest Asystole Adult

It was agreed that pulse checks be removed following CPR. Pulse however should be checked after a rhythm change but this is a training issue. It was agreed that APs be advised that they go to the end of the algorithm and are not time specific for transport. This is to be included on all cardiac arrests CPGs.

CPG 2a FBOA Adult – L1 to 3

It was agreed to move up the telephone symbol/advisory box to immediately follow after patient becomes “unresponsive”.

There was discussion regarding evidence on the practice of using back blows versus abdominal thrusts. It was agreed to leave as presented.

It was agreed that “severe” be changed to “complete” and “mild” be changed to “partial”. A question mark i.e. “?” be entered into all choice boxes. Insert “was” prior to “CPR, abdominal thrusts or O₂ required”.

CPG 2a – FBAO – Adult – EMT, P AP

It was felt that the layout was like a task analysis and was unnecessary for these levels. The changes agreed for L1 to 3 are also to be included. A discussion on the merits of including needle cricothyroidotomy ensued. It was agreed that it would have little benefit as the obstruction would probably be below the insertion point. It was agreed however that this skill should be included for Advanced Paramedics for trauma patients.

CPG 2b & 2c FBAO – Paediatric

The changes agreed with FBOA Adult also applied to Paediatric FBAO and are to be changed accordingly.

The issue of Paediatric intubation was discussed as raised by Dr Mags Bourke in the Delphi feedback . It was agreed that in this case, the child would be dead, unless intubation was attempted. The Chair agreed to discuss the issue with Dr Bourke.

CPG 3b – Cardiac Arrest – Asystole – Decision Tree

A distinction was made between an unwitnessed asystolic cardiac arrest with no CPR and a witnessed arrest. The algorithm should reflect this when deciding to cease resuscitation. It was felt that observing asystole on a monitor for 30 seconds was inappropriate as CPR should be ongoing.

It was agreed that a question mark be inserted at end of all diamond box texts.

Resolution: That the Batch 3 Delphi CPGs be approved with the above amendments.

Moved: Declan Lonergan

Seconded: Lawrence Kenna

Mr Brian Power requested that members on receiving the draft batches of CPGs send any general feedback to him before the Delphi feedback is requested.

He also noted that there was a high level response from the Training and Development Officers for the Delphi process and complimented them on same.

3.2 Batch 4 CPGs – carried to next MAG

3.3 After Care Instructions – Diabetes – carried to next MAG

4. **Red Card Protocol** – carried to next MAG

5. **Director's update**

Carried over to next MAG.

6. **Standards – Education and Training Standards**

The Director reminded members that feedback on the final draft Education and Training Standards was due back to Pauline Dempsey by Friday 13th October.

7. **AOB**

Outstanding items carried to next MAG

Signed:

Date:

Mr. Mark Doyle,
Chair

Meeting Report of Medical Advisory Group Meeting held on the 28th November, Boardroom, PHECC Offices, Abbey Moat House, Abbey St, Naas, Co Kildare.

Present Mark Doyle (Chairman)
Cathal O'Donnell
Macartan Hughes
Brendan Whelan
Martin O'Reilly
Sean Creamer
Laurence Kenna
David Janes
Vincent O'Connor

Apologies Richard Lynch
Fergus McCarron
Fergal Hickey
Julie Woods
Danny O'Regan
Stephen Cusack
Gerard Bury
Conor Eggleston
John O'Donnell
Michael Seaman
Paul Robinson
Declan Lonergan
Geoff Keye
David Hennelly

In Attendance Brian Power
Jacqueline Egan
Geoff King
Patricia Leng

1. Chairman's Business

No matters discussed.

2. Meeting Report and matters arising

2.1 Meeting Report

Resolution: That the meeting Report of the Medical Advisory Group of 14th November 2006 be agreed.

Moved: Mr Macartan Hughes
Carried without dissent

Seconded: Dr Cathal O'Donnell

2.2 Matters arising

The Chairman advised the meeting that the spirit of the discussions that took place at the previous meeting was inaccurately reflected with regard to the resolution to develop an expert group. The Director stated that MAG was the expert group and that when required input could be sought from the appropriate specialists.

Resolution:

The concept of further developing MAG as the expert group was agreed by members.

Moved: Mr Martin O'Reilly
Carried without dissent

Seconded: Mr Brendan Whelan

2.3

4. Treat & Discharge

Dr. Cathal O'Donnell circulated a sample 'Aid to Capacity Evaluation' and it was proposed to include "Treat & Discharge" as an agenda item at the next MAG meeting so that the matter could be discussed in depth. Dr Cathal O'Donnell was asked by the Chairman to take the lead in this regard.

2.4

5.1 Heparin

The meeting was advised that Heparin does not require refrigeration.

3. CPG Review

3.1 Delphi 5

CPG – A11 Level 5 & 6

The following were agreed:

The post seizure arm go directly to check blood glucose box.

Replace Lorazepam with Diazepam IV/IM and Midazolam buccal.

Increase blood glucose range to > 20 mmol/L.

Insert additional diamond with "The patient was not seizing on arrival, has a history of seizures, has no injury".

In discharge box replace "relative or friend" with "competent carer".

MAG Meeting Report

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Insert an instruction box with “consider other causes of seizure”.

CPG – A57 Level 5 & 6

The following were agreed:

For post seizure arm go directly to “if pyrexial – cool child” box.

Replace Lorazepam with Diazepam IV/IM and Midazolam buccal.

A debate ensued regarding paediatric age range. No decision was reached and Dr. David Janes agreed to contact Dr. Walsh, Consultant Paediatrician, Our Lady’s Hospital for Sick Children, Crumlin in order to get a paediatric opinion. Following his feedback, all MAG members will be surveyed if required.

CPG 1d Level 5 & 6

The following were agreed: Remove “& tone” from evaluation diamond

Insert “IO” for epinephrine route.

Insert “consider Naloxone if mother is IVDU” after Epinephrine.

Change Hartmann’s solution to NaCl.

Remove “consider ceasing resuscitation” box.

CPG 3c Level 4 to 6

It was agreed that EMTs should not enter the : “End stage of terminal illness” arm of this CPG. The following changes were agreed:

Insertion of an additional diamond containing “Consensus between care giver and practitioner on not resuscitating” after “did not want resuscitation” diamond.

Change “indicators of death” to diamond with No option going to CPG 4a.

For indicators of death reference, insert “obvious” prior to “rigor mortis” and “pooling”.

Delete “disposal” and change “dead bodies” to “deceased” in final direction box.

CPG 3c Level 1 to 3

It was agreed to insert “obvious” prior to “rigor mortis” and “pooling” For indicators of death reference.

CPG 9a Level 5 & 6

It was agreed to insert instruction box re doctor and midwife into algorithm below request ALS and insert an instruction box containing “If no progress with labour consider transporting the patient”.

CPG 9c Level 5 & 6

The following were agreed: Under “support the baby” box insert a diamond containing “successful delivery”. If No, insert a feedback arrow to “support the baby” box for Paramedic and only Advanced Paramedic to progress with the remainder of the algorithm.

Change wording in diamond from “nape of neck visible at vulva” to “Nape of neck anteriorly visible at vulva”.

Reverse order of “Place hand on baby’s face” box and “grasp baby’s legs” box.

CPG 9a Level 4

Agreements were reached on the following:

Insert the instruction box re doctor and midwife into algorithm below request ALS.

If yes to birth complications transport and treat patient.

Following birth transport and treat patient

Insert instruction box "Rendezvous with practitioner, doctor or midwife en-route to hospital".

CPG 9a Level 3

MAG members were very happy with the algorithm, however several members present expressed concern over a CPG on childbirth for EFR. Members present alluded to Paramedics and Advanced Paramedics having great difficulty coping with pre-hospital emergency childbirth, both clinically and emotionally. The question of appropriateness to include EFRs was debated without conclusion.

Resolution: That Delphi 5 CPGs excluding CPG 9a Level 3 receive interim approval subject to the above amendments.

Moved: David Hennelly

Seconded: Macartan Hughes

Carried without dissent

3.2 Delphi 6 – carried to next MAG

3.3 Paediatric Defibrillation Feedback

Ms Jacqueline Egan outlined the responses received with regard to the paediatric defibrillation survey. Feedback received was discussed and it was agreed that it was inappropriate to include paediatric defibrillation at responder level. Should organisations wish to include defibrillation at this level it would be in addition to the PHECC minimum standard.

3.4 Aide Memoire Feedback

Ms Jacqueline Egan outlined responses received with regard to an Aide Memoire for use in paediatric drug dose calculation. Discussion followed regarding the most appropriate type of tape to use. A recommendation was made by the group that the Braslow Tape is the most appropriate for use in pre-hospital and an EMS Field Guide will be developed to supplement CPGs Edition 3.

4. Education and Training Standards

The Director outlined to the group that it is intended that the PHECC Education and Training Standards will become effective on the 31st March, 2007. The net effect of this is that from that date onwards no further Conversion Courses may commence and any individuals who have not commenced a Conversion Course by that date will no longer be able to do so. Successful completion of this course will lead to an NQEMT Paramedic Award. After the 31st March 2007 any

individual who wishes to acquire an approved NQEMT Paramedic award may only do so by completing the full PHECC course and PHECC examination.

5. PCR Edition 2

Ms Jacqueline Egan informed the group regarding the development of PCR Edition 2 and discussion ensued regarding the proposed removal of Rate from Breathing and Circulation section of the Primary Survey. In the Breathing section it was agreed not to include rate but to include the words 'fast' and 'slow' after the word 'Abnormal' and in Circulation to return 'rate' to Pulse and this would be entered as a numeric by the practitioner.

5.1 CUPS

It was outlined that CUPS will be replaced by Clinical Status (CS) which includes the following elements: Life Threatening, Serious Not Life Threatening and Non Serious or Life Threatening.

5.2 Thrombolysis

The addition of Thrombolysis consent was discussed and the Chairman stated that he will review the wording and return same as appropriate.

5.3 Handover of Care

The elements of handover of care between practitioners were outlined.

Discussion ensued regarding the use of the Clinical Audit tick box and it was agreed that as part of the guidelines in the use of PCR Edition 2 it would be outlined to practitioners that they expand their clinical audit reason in 'Additional Information'.

Dr. Cathal O'Donnell suggested that consideration should be given to the inclusion of a patient capacity evaluation being completed in instances of patient refusing transport. He circulated a sample Aide to Capacity Evaluation for review by the group.

6. Directors Update

The Director briefed members on the following items: PCR; ePCR and the Register and CPGs. He outlined that 1300 practitioners had joined the register to date and in due course it will be made available to organisations other than Statutory Services. He stated that there is a requirement to increase the support to Brian Power, Programme and Development Officer, in the development of Edition 3 CPGs and this would be addressed.

6.2 Out of Hospital Cardiac Arrest Register

The Director informed the group that the North-West Area has established a pilot scheme for an Out of Hospital Cardiac Arrest Register which will dovetail well with the PHECC Information System currently being implemented.

7. AOB

Signed:

Date:

Dr Mags Burke
Vice - Chair



Meeting Report of the PHECC Medical Advisory Group held at the Headquarters of the Ambulance Service of the HSE – Eastern Region, Phoenix Hall, Dublin on Tuesday 1st March 2005 at 10:00

Present:

Mark Doyle (Chair)
John Burton
Mags Bourke
Sean Creamer
Lawrence Kenna
Declan Lonergan
Macartan Hughes
Fergus McCarron
Danny O'Regan
Martin O'Reilly
Michael Seaman
Brendan Whelan
Julie Woods

Apologies:

Stephen Cusack
Conor Egleston
Peter O'Connor
John O'Donnell
David McManus
Paul Robinson
Tony Ryan

In attendance:

Pauline Dempsey, Programme Development Officer
Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Geoff King, Director
Brian Power, Programme Development Officer

1.0 Chair's business:

2.0 Meeting Report of the MAG, held at the PHECC Office, Naas on the 28th October 2004.

The following edits to the October Meeting Report were requested by members: – Page 3 CPG-A 7 Adult Asystole – typo – edit to read “Cease resuscitation if patient is not: hypothermic, cold water drowning....”

Page 4 – CPG-A 57 Seizure disorders/convulsions – after max dose of Lorazepam delete “/kg” i.e. should read max dose of 4mg.

Page 5 – CPG-A 58 Severe Pain Management - typo – amend “terminal” to read “thermal”.

Meeting Report agreed with the above amendments

2.1 Matters arising:

It was outlined by the Director that Dr Stephen Cusack will present information which relates to issues on “medical oversight” at a future MAG meeting.

Mr Declan Lonergan reported that he will return to MAG at a future date with details on the use of Lund and Browder burns classifications as used in the Health Service Executive (HSE) – South Eastern Area.

It was suggested by the group that all edited CPGs and CPG-As should be sent to members with highlighted changes, in order to improve the review process of all the amendments.

3.0 EMT assessment sheets

3.1 19.2 Normal Childbirth (post delivery). Concern was raised at an Accreditation Committee Meeting regarding the practice of abdominal massage. It was agreed that the 2nd last line would be revised to read “Massage the abdomen in a circular motion after the placenta is delivered to stimulate contraction of the uterus if post-partum haemorrhage is present” (verbalise).

3.2 1.1 and 1.3 (assessment sheet 1) AED in cardiac arrest (VF & VT). The number of critical elements on this assessment sheet was discussed. It was agreed to leave the item of “1st shock within 90 sec of arrival of AED” as test item but not as a critical element, subsequently leaving only two critical elements on this assessment sheet.

3.3 Assessment sheet 3a & 3b CPR Adult, Infant and Child (3.1 - 3.5). The number of critical elements on this assessment sheet was also raised for discussion. The Director requested clarification from MAG regarding the number of critical elements per skill station and per assessment sheet. It was agreed to limit each skill to 2 critical elements. The issue of assembling of equipment as a critical element was raised and it was agreed to remove equipment assembly and checks on assessment sheets.

3.4 Assessment sheet 8a: Ambulance trolley stretcher positions
Following a discussion on the limited use of the Trendlenburg position pre-hospital, it was agreed this would be removed. In the long term

the assessment of trolley stretcher positions and blanketing would be written into other OSCEs.

The Director agreed that PHECC would return to MAG with:

- Revised assessment sheets;
- A formal decision for two Critical elements per skill and rule/requirement to pass both elements.

4 EMT-A (Advanced Paramedic)

4.1.1 **Assessment Sheets:** The Director outlined that the assessment sheets were distributed to members as a first draft. He stated that they will be substantially refined by PHECC and returned to the first cohort to be further refined by them.

The Director also acknowledged the feedback already received from some members on the current draft of the assessment sheets.

The following issues were highlighted on the assessment sheets which need to be addressed:

Relationship/communications

It was agreed that the new approach for the assessment of communication /teamwork with clinical responsibility be addressed.

Critical Elements

It was agreed to reduce the number of Critical Elements to 2 per skill and would feature one element that would prioritise safety and have major impact on patient care.

Verbalise

It was agreed by MAG that “verbalise” has a role on assessment sheets.

4.1.2 **Needleless and sharps**

The issue of “Needleless and sharps” in examination was highlighted. The need to accommodate best practices in the pre-hospital environment was noted and it was stipulated by the Director that the “needleless” approach should be promoted but it should also be acknowledged that sharps will be required in some circumstances.

4.1.3 **Checking equipment and scene safety:** it was agreed that “checking equipment” be removed from each OSCE, the possibility of a pre-shift check OSCE was suggested.

4.1.4 **Clinical Documentation - PCR:** The Director outlined that Council agreed at their previous meeting to implement the PCR in all HSE – areas except the HSE – Eastern, South Eastern and North Eastern areas. The Chair outlined that all OSCE examinations should be based on this PHECC PCR.

4.2 Ms Julie Woods distributed draft documents on the process of assessment for EMT-AP; “PHECC Paper of Principles” and “Advanced Paramedic MCQs”. The first document outlined the structure of the Short Answer Examination phases of training and assessment for Block 2 to 6. It was highlighted that 3 questions must be answered from Section A and a choice of 3 questions out of 6 for Section B.

Dr Mags Bourke agreed to review the weightings on MCQs and to forward all her recommended changes to the PHECC Office and from that Ms Julie Woods will ensure that congruence on these issues will be obtained from the Test Item Writing Group.

MAG agreed in concept to the documents above.

5. **Amendments to Medical Products Regulations**

The amended document was distributed to members for information purposes. Further to queries at the previous MAG regarding current published literature of guidelines on Ondansetron, Dr Mags Bourke informed the group that Ondansetron would not be taught as it is not appropriate for use pre-hospital. It was therefore agreed by members that students / institution should be informed that they will not be examined on Ondansetron even though it will remain on the schedule of drugs.

6. **Register**

The Draft Conceptual Framework was distributed to members for information purposes and the Director updated MAG on the current process.

7. **Clinical Handbook**

The Director updated members on the dissemination and implementation of the Clinical Handbook and distributed copies of correspondence which was sent to each CAO, CFO (DFB) and CEO requesting their commitment to the implementation of the Clinical Handbook.

8. **Patient Care Report (PCR)**

The following documents were distributed for review by members:

- PCR Edition 1
- Patient Care Report Guidebook
- Glossary of Terms

The Director requested that members reviewed the Patient Care Report Guidebook, the Glossary of Terms and the Data set (as distributed at previous meeting), and to forward all correspondence to the PHECC Office ASAP as the above documents need to be ratified and finally approved at the upcoming Council Meeting. He reiterated the urgency and the need for MAG's input on these matters.

9. Merit Project

The project aims of the Medical Emergency Responders Integration & Training (MERIT) were distributed for information purposes and the Director updated members on the current status of the project.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair



Meeting Report of the PHECC Medical Advisory Group held at the PHECC Office on Thursday 19th May 2005 at 10:30

Present: Mark Doyle (Chair)
John Burton
Stephen Cusack
Conor Egleston
Lawrence Kenna
Declan Lonergan
Richard Lynch
Peter O'Connor
Vincent O'Connor
Martin O'Reilly
Brendan Whelan
Julie Woods

Apologies: Mags Bourke
Macartan Hughes
John O'Donnell
Sean Creamer
Fergus McCarron
Paul Robinson
Michael Seaman
Danny O'Regan
Fergal Hickey

In Attendance: Pauline Dempsey, Programme Development Officer
Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Geoff King, Director
Brian Power, Programme Development Officer

1. Chairperson's business:

The Chair welcomed Dr Richard Lynch, Consultant Emergency Medicine, from the HSE – Midland Area, Midland Regional Hospital Mullingar. Dr

Lynch has replaced Dr Cyrus Mobed as the Ambulance Medical Advisor for HSE Midland Area.

2. Meeting Report

Resolution: That the Meeting Report of the Medical Advisory Group Meeting of 1st March 2005 be agreed.

Moved: Julie Woods

Seconded: Peter o'Connor

3. Matters arising

3.1 EMT Paramedic Primary Assessment Sheets

Revised Primary Assessment sheets with two critical elements per skill were circulated to the group for discussion. Ammendment were suggested to the following assessment sheets:

2a – Foreign Body Airway Obstruction - delete line 4 & 5 and amend line 3 to read “Correctly perform abdominal thrusts (or chest thrusts if obese/pregnant)”.

2c – Foreign Body Airway Obstruction(Conscious Child) & Recovery Position - delete line 4 & 5 and amend line 3 to read “Correctly perform abdominal thrusts”.

1.2 – AED in Cardiac Arrest (Asystole – Cease Resusscitation) - remove VF from the assessment sheet to ensure consistency with CPG, and insert ‘found in asystole’. Martin O’Reilly raised concerns regarding the compatibility of this assessment sheet – AED in Cardiac Arrest (Asystole – Cease Resusscitation) and CPG 3B – Cardiac Arrest - Asystole Decision Tree. It was agreed to revise the assessment sheet to reflect the Cardiac Arrest Asystole Decision Tree CPG 3B. Lawrence Kenna agreed to document any comments he had collated regarding the EMT Paramedic assessment sheets and forward to PHECC.

The Director outlined that PHECC would initiate a ‘Realignment’ project in the near future, the objective of which would be reallign CPGs, assessment sheets, skill lists, competencies and clinical procedures.

Resolution: that EMT Paramedic Primary Assessmnet sheets are approved subject to 1) feedback from members 2) the outlined ammendment being made following which all members will be circulated with same.

Moved: Vincent O’Connor

Seconded: Julie Woods

3.2 Secondary Assessment Sheet:

19.2 - Normal Childbirth (post delivery).

It was agreed that a CPG should be developed for management of post-partum haemorrhage which would cover placenta delivered/undelivered. The CPG will be presented to MAG as appropriate.

Resolution: The Normal Childbirth (post delivery) assessment sheet 19.2 is approved.

Moved: Martin O'Reilly **Seconded:** Conor Egleston

4. EMT-A (Advanced Paramedic) assessment sheets

101.1 – Adult Symptomatic Bradycardia - Agreed

101.2 – Adult Cardiac Chest Pain Management - Agreed

101.3 – Amend – change “pulselessness” to “bradycardia less than 60 with signs of poor perfusion”

Agreement from the group was sought on the definition of adult bradycardia being <60 bpm.

102.1 – Advanced Airway Management – agreed

102.2 – Adult Persistent FBAO – delete line “please stop and recommence at the point following laryngoscopy and this time the foreign body is not visible”. There was agreement from the group that all intubation elements from 103.1 into 102.2 be inserted into assessment sheet 102.2

103.1 – Agreed.

It was also agreed there was a requirement to develop a Communication assessment sheet in a scenario format.

The Director informed members that the assessment sheets for the EMT-A (Advanced Paramedic) course are still in developmental stage and requested all feedback or comments from MAG members. He stipulated that PHECC would collate all feedback and present to the Chair for approval for use with the 2nd Cohort of EMT-AP candidates. The Director also outlined that the training institution will sign off the competency of the candidate through the log book process but PHECC retains the right to examine the procedure.

5. Medication Formulary-

Members sought clarification on cold storage of drugs. This is to be further researched by PHECC and brought back to MAG with information as appropriate.

The following amendments to the medication formulary were agreed:
Paracetamol – change administration to read “Oral PO and PR if PO not possible”. This is also to be reflected in the CPG-As

Morphine – Change contra-indications from systolic BP <100 mmHg to systolic BP of <90 mmHg.

Lidocaine – change dosage to max of 3mg/kg in adult and also 3mg/kg in paediatric.

Resolution: That the Medication Formulary be approved subject to amendments.

Moved: Connor Egleston **Seconded:** Declan Lonergan

6. Cardiac First Responder Standard

The Director outlined the development of the Cardiac First Responder Standard and requested robust feedback from all members.

7. Register

The Director invited robust feedback on current position of the PHECC register.

8. Patient Care Report (PCR)

Jacqueline Egan informed the group that it is proposed that the implementation process for the Patient Care Report would take place in 5 HSE regions and Dublin Fire Brigade as follows: Southern, Mid-Western Western, North Western, Midland and DFB. A draft Implementation Process Plan was circulated and feedback was welcomed.

The issue of DNR orders was highlighted and it was agreed to come back to MAG with further information on this issue as appropriate.

9. CPG – AED Paediatric

The first draft of CPG was distributed to members and feedback requested.

10. Ships at Sea Service - Presentation

Dr Stephen Cusack presented to members a very worthwhile presentation outlining the National Ships at Sea Service provided by the Maritime Medical Advisory Group/Medico Cork. Following the presentation the draft Conceptual Framework for Medical Oversight was circulated and members were asked by the Chair to consider aspects of Dr. Cusack's presentation and it's relevance to "Medical Oversight" for the Ambulance Service.

11. AOB

The Director circulated his response to correspondence from the Corrib Gas Project enquiring regarding the administration of IV fluids and suturing of wounds by EMTs. The Director also circulated correspondence from the Irish Mountain Rescue Association i.e. their interest, and that of the Irish

Cave Rescue Organisation in applying for organisational approval from PHECC to implement all or selected CPGs

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair

Meeting Report of the PHECC Medical Advisory Group held at Ratra House, Civil Defence Training School, Phoenix Park, Dublin on Wednesday 31st August 2005 at 5:00pm

Present: Mark Doyle (Chair)
John Burton
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Vincent O'Connor
Cathal O'Donnell
Danny O'Regan
Martin O'Reilly
Fergus McCarron
Brendan Whelan

Apologies: Sean Creamer
Conor Egleston
Fergal Hickey
Richard Lynch
Paul Robinson
Michael Seaman
Julie Woods

In Attendance: Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Geoff King, Director
Brian Power, Programme Development Officer

1. Chairperson's business:

The Chair welcomed Dr Cathal O'Donnell, Consultant Emergency Medicine, from the HSE – Mid Western Area, Limerick to the MAG.

2. LUCAS Chest compression system presentation

Mr Colin Thomas, Staffordshire Ambulance Trust, presented a very worthwhile one hour overview on the use and benefits of the LUCAS CPR Chest Compression System.

3. Meeting Report

Resolution: That the Meeting Report of the Medical Advisory Group Meeting of 19th May 2005 be agreed.

Moved: Martin O'Reilly

Seconded: John Burton

Carried without dissent

3.1 **Matters arising**

Ms Jacqueline Egan informed the group that revised assessment sheet 1.2 AED in cardiac arrest (asystole – cease resuscitation) with changes as outlined and agreed at the previous MAG meeting – replacement of VF with Asystole – was placed on the PHECC website prior to returning it to MAG. This needed to be done due to the assessment rule which states that the most recent version of the assessment sheets must be put on the web 60 days prior to the exam date.

4. **EMT (Paramedic) CPGs**

4.1 CPG 3b Cardiac Arrest – Asystole Decision Tree

CPG 3b Cardiac Arrest – Asystole Decision Tree was discussed with a view to incorporating a CPG for a person found in a rhythm other than asystole on the arrival of the EMT and subsequently goes into asystole. The office welcomes assistance in this regard. It was agreed that a letter of clarification regarding the application of CPG 3b would be circulated to the ambulance services.

4.2 Cardiac First Response

The first draft of the Cardiac First Response CPG was distributed to members for their review in conjunction with the Cardiac First Response Standard. The Director outlined that the draft Standard may be implemented on a trial basis in the Statutory ambulance services (see 8.1).

4.3 Paediatric Defibrillation CPG

Discussion ensued in relation to the availability of Paediatric Defibrillators in the services. It was agreed that the office would return to the Group with a revision to the CPG in the form of an information box being included regarding the type of equipment which the CPG can be used with.

4.4 CPG Implementation feedback from Voluntary organisation - Order of Malta

The feedback on CPGs received from the Order of Malta was distributed to members for their information. This and other feedback will be collected for further consideration by MAG.

5 **EMT (Paramedic) Assessment Sheets**

5.1 Revised assessment sheet (Primary) 1.2 AED in Cardiac Arrest – Asystole Cease Resuscitation

The revised assessment sheet (Primary) 1.2 AED in Cardiac Arrest – Asystole Cease Resuscitation was distributed for discussion.

The Director outlined that the CPG realignment project has commenced and that PHECC will return to the group with information as appropriate.

5.2 Triage Sieve OSCE

The use of prompt cards was discussed and a vote was taken on the use of prompts cards at the Triage Sieve OSCE. The vote was carried and the Prompt cards will be used as an aide memoire in all Triage Sieve OSCE's in future.

Recommendation: That prompt cards be used in all Triage Sieve OSCE's.

Moved: Danny O'Regan
Carried without dissent

Seconded: Martin O'Reilly

6 EMT-A (Advanced Paramedic) CPG A

6.1 CPG-A 4 Adult Anaphylaxis

The revised CPG-A 4 Adult Anaphylaxis – version 2.3 was agreed.

Recommendation: That MAG approve CPG-A 4.

Moved: Vincent O'Vonnor

Seconded: Fergus McCarron

7. EMT-A (Advanced Paramedic)

7.1 The following changes to CPG-A algorithm were discussed and agreed:

7.1.2 CPG-A 5 – Adult Ventricular Fibrillation and Pulseless Ventricular Tachycardia

The following line be inserted under Lidocaine 1-1.5 mg/kg -
“*Until Amiodarone Minijet available – use Lidocaine 1-1.5 mg/kg*”

7.1.3 CPG-A 11 – Adult Seizure Disorders/Convulsions

“*Still seizing and episode > 4 mins*” to be removed and replaced with
“*If sustained seizure activity*”

7.1.4 CPG-A 57 – Paediatric Seizure Disorders/Convulsions

“*Still seizing and episode > 4 mins*” removed and replaced with
“*If sustained seizure activity*”

7.2 The following changes to the Medication Formulary were discussed and agreed:

7.2.1 Aspirin – In indications for use include – “suspected MI”

It was suggested by the group that a CPG-A for Silent MI should be developed. The office welcomes assistance in this regard.

7.2.2 Diazepam - In Indications for use “Prolonged seizure > 4 mins.” was removed and replaced with “sustained seizure activity”.

7.2.3 Lorazepam - In Indications for use “Prolonged seizure > 4 mins” was removed and replaced with “sustained seizure activity”.

7.2.4 Nalaxone – In additional information include the following text “Use with

caution in pregnancy” and in Contra-Indications the following line was removed
“pregnancy unless under medical instruction”

Recommendation: That MAG recommend to Council the approval of the CPG-As and the Medication Formulary (as Edition 1) for use by the first co-hort of Advanced Paramedics during their internship.

Moved: Brendan Whelan
Carried without dissent.

Seconded: Fergus McCarron

8. Standards

8.1 The Cardiac First Response standard and related Instructor Standard

The Education and Training Standards for Cardiac First Response and related Instructor Standard, Emergency First Response, Emergency Medical First Response and Paramedic were distributed to members for review and feedback.

Recommendation: That MAG recommend to Council the approval of the Cardiac First Response Standard and related Instructor Standard for implementation on a trial basis in the Statutory Ambulance Service.

Proposed: Martin O'Reilly

Seconded: Brendan Whelan

9 Patient Care Report – implementation update

Jacqueline Egan updated the group on the current stage of the implementation of the PCR and highlighted the fact that the Patient Care Report is in use in the HSE Southern Area, and Mid Western area. Training has commenced in DFB with implementation to commence on September 29th. HSE North West and HSE Midland to commence PCR training and implementation in September. HSE Western will be commencing training and implementation of the PCR at a date to be decided.

10. AOB – The Director outlined Prof Finucane’s report on the Distance Learning Module Advanced Paramedic course and the NATS/UCD Response. PHECC intends to distribute the report to the EMT-A course candidates.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle, Chair



Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Thursday 29th July 2004 at 10:00

Present:

John Burton
Sean Creamer
Mark Doyle
Joe Foy
Lawrence Kenna
Declan Lonergan
John O'Donnell
Danny O'Regan
Martin O'Reilly
Fergus McCarron
Cyrus Mobed
Michael Seaman
Julie Woods

Apologies:

Mags Bourke
Gerry Bury
Stephen Cusack
Fergal Hickey
Macartan Hughes
Conor Egleston
Patrick Plunkett
Peter O'Connor
Vincent O'Connor
Paul Robinson
Tony Ryan
Brendan Whelan

In attendance:

Sharon Gallagher, Support Officer Programme Development
Jacqueline Egan, Programme Development Officer
Geoff King, Director
Brian Power, Programme Development Officer

2.0 Meeting Report of the MAG, held at the PHECC Office, Naas on the 11th December 2003 agreed.

Resolution: Meeting Report agreed

2.1 Matters arising:

*The Chair welcomed new members to MAG;
Mr Brendan Whelan MHB (Acting T&D)
Mr John O'Donnell WHB (Consultant A&E)*

Mr Danny O'Regan SHB (T&D)

Ms Jacqueline Egan was also welcomed by the Chair as PHECC Programme Development Officer in temporary replacement for Ms Pauline Dempsey.

The Chair commented on the low turnout of medical representatives at MAG and asked for ideas from members on how to improve medical involvement/attendance.

3.0 CPG-As

The Chair informed members that the CPG-As will not be formally published until after the trial period used by the first cohort of EMT-A students. All recommendations will be presented to the MAG sub-committee. The first 14 CPG-As for Adults have been approved by the subgroup. The Paediatric CPG-As were developed by the subgroup using email and also require approval by MAG.

Adult CPG-As (1-14)

- | | |
|--|----------|
| CPG-A 1 Adult Advanced Airway management | - agreed |
| CPG-A 2 Adult Persistent foreign body airway obstruction | - agreed |
| CPG-A 3 Adult Inadequate respiration | - agreed |
| CPG-A 4 Adult Anaphylaxis - minimum time frame between repeat adrenaline to be included on CPG-A | - agreed |
| CPG-A 5 Adult VF & PVT use lignocaine until amiodarone becomes available in minijet form | - agreed |
| CPG-A 6 Adult PEA | - agreed |
| CPG-A 7 Adult Asystole | - agreed |
| CPG-A 8 Adult symptomatic bradycardia | - agreed |
| CPG-A 9 Adult Cardiac Chest Pain | - agreed |
| CPG-A10 Adult Pain management | - agreed |
| CPG-A11 Adult Seizures Disorders/Convulsions queried administration of diazepam PR, amend to "if IV or IM not an option administer diazepam PR" | - agreed |
| CPG-A12 Adult Glycaemic Emergencies | - agreed |
| CPG-A13 Hypovolaemic shock – remove head injury and replace with evidence of major trauma | - agreed |
| CPG-A14 spinal immobilisation – "blunt" and "penetrating" trauma to be amalgamated to read "trauma" and decision tree under penetrating trauma to be removed. At bottom of decision tree the section - "presence of ...or inability to communicate" to be moved and included in section under "anatomic deformity of spine?" | |
| The bottom right hand side of decision tree "immobilisation not indicated – transport" to be removed | - agreed |

It was agreed to use milligrams for medication dosages for all CPG-As. Those present highlighted the importance of having consistent terminology across all CPG-As.

The numerical format of adult and paediatric CPG-As was agreed, CPG-A 1 to 49 for Adults, and CPG-A 50 upwards for Paediatrics.

It was agreed by members that an inclusion in the introduction to the CPG-As should outline a generic definition of “medical oversight” with a framework principal. This was agreed to be revised by PHECC and returned to MAG.

Paediatric CPG-As:

- CPG-A 50 Asystole/PEA – to include Atropine - agreed
- CPG-A 51 VF & PVT use lignocaine until amiodarone becomes available in minijet form - agreed
- CPG-A 52 Bradycardia - agreed
- CPG-A 53 Hypoglycaemia - agreed
- CPG-A 54 Hypovolaemic shock - agreed
- CPA-A 55 Anaphylaxis In second decision tree in adrenaline text box, delete IV slowly and replace with “repeat IM dose” - agreed
- CPG-A 56 Respiratory distress - agreed
- CPG-A 57 Seizure disorders/convulsions include Lorazepam as option instead of diazepam, also IM option to be included - agreed
- CPG-A 58 Severe Pain Management agreed to remove “cyclizine”. It was also agreed to include “Wong-Baker faces” as information box - illustration of pain level 0-10. - agreed

Resolution: The CPG-As 1 – 14 and CPG-As 50 -58 be approved as a working draft for 1st Course of EMT-A subject to the agreed amendments

Proposed by: Declan Lonergan **Seconded by:** Cyrus Mobed

4.0 Infection Control Guidelines:

The draft “Ambulance Service Guidelines for situations associated with Biological Threats” produced by HeBE were distributed with correspondence from PHECC Director. These guidelines include the transport of patients with infectious diseases, decontamination of Ambulance and crews, and personal protective equipment.

It was discussed by the Director and members that PHECC would draft Infection Control Guidelines and present back to MAG.

Martin O’Reilly from DFB outlined that DFB Training School had produced some guidelines in the area already and would provide to PHECC.

Resolution: It was agreed that PHECC would draft Infection Control Guidelines and present back to MAG.

Proposed by: Fergus McCarron

Seconded by: Michael Seaman

5.1 National PRF :

The second draft of the PRF had been distributed to members with correspondence letter which was sent accompanying draft 2 to all stations. The compilation of services report was also distributed prior to meeting outlining findings of National PRF Trial. Mr Seán Creamer, Project Officer, outlined that draft 2 had been well received by the Volunteers.

Draft 4 was then distributed to members, Mr Creamer outlined that it was not a final document but it will be the main face of the electronic PRF, and members were requested to review all sections of the form in order to refine the final version. Members complimented the work put into draft 4 and its end result.

Mr Cyrus Mobed highlighted that the “A/E Rec. Staff signature” section of draft 4 needs correct wording/clarity for A/E staff. Mr Mobed agreed to devise appropriate wording and return to MAG.

5.2 Data set and definitions & Glossary of Terms:

The Director stipulated to members that the data set, data definitions and glossary of terms needed to be given considerable time and scrutiny by all members. The data set and glossary of terms need to be 100% in tune with the PRF final draft. The Chair requested members to examine the documents conceptually and individually and to forward any feedback or recommendations to the PHECC Office over the coming 8 weeks. The feedback will be collated from all members to form core discussion and will be presented and discussed at next MAG meeting.

A draft document – Comparative Analysis of PHECC PRF data was distributed to members for their information. The analysis compares PHECC dataset to JRCALC, UK/TENAX, European CARDS project, GP/Primary Care, and Acute Hospitals. This analysis will assist members in benchmarking the PHECC dataset with that of other services.

6.0 Exam Review:

The NQEMT examination review document which was reported/presented to Council was distributed to members for their information. Mr Brian Power outlined that the initial process for nomination of examiners involved both training institutions being requested to submit names for consideration as examiners.

7.0 Clinical Handbook

The newly printed 2nd Edition CPG Manual was distributed to members as a draft for information and review. The Director outlined that the manual has not been officially published by Council. He also outlined that all CEOs will be written to regarding implementation of the revised CPGs based on the premise of other providers' criteria as outlined in introduction on Manual, all correspondence will be copied to CAOs.

Mr Declan Lonergan agreed to update the implementation package for training purposes pending approval by Council and distribution to CEOs.

All members were requested to read the manual and to come back to MAG with 1) urgent changes and 2) recommended changes for next edition.

8.0 Update by Director:

8.1 EMT-A/S.I.

An extract from SI No *** of 2004 was distributed to members, outlining definitions of; Pre-hospital emergency care provider, pre-hospital emergency care service, Advanced Paramedic, Paramedic, and Emergency medical technician. The Chair acknowledged some differences of opinions from members on labels/definitions outlined. The Director explained that the definitions outlined were a Council matter and have been progressed and accepted.

8.2 ICT Package

Mr Seán Creamer informed members that an ICT pack was sent to each station and Training & Development Officer of all health boards. The Pack consisted of ALS Paramedic level CD, neonatal resuscitation book, PHTLS book, and a Body works CD.

8.3 Auxillary & Voluntary Conference

The Feedback report of the "Sharing the Vision" - Auxillary and Voluntary Emergency Care Providers Conference held on the 2nd March was distributed and discussed along with the PHECC Voice (newsletter). The conference which was the first of its kind to be held by PHECC was seen by all as a success.

9.0 Control Working Group

A draft letter to Controllers was distributed to members with a training framework for Emergency Medical Controller Training devised by the CWG. Members were informed that this letter subject to some minor amendments will be sent to all Command and Control Centres in the country with the draft training framework for information purposes.

10.1 Assessment Sheets

The new assessment sheets outlined below were distributed for approval:

19.1 Normal childbirth – It was agreed that timing (8 minutes) needs to be reviewed before agreement , also query on multiple birth (also for CPG 9 multiple birth not referenced)

19.2 Normal childbirth (post delivery) - agreed

The above assessment sheets were approved for use in assessment/examination but exam quality committee will be made aware of time restrictions

9.1 Completing a PRF – PRF needs to be specified, dataset needs to fit. The text for scenario of this assessment needs to be reviewed and needs to come back to MAG. - agreed

9.2 Patient History taking – open questions were highlighted as being subjective and it was agreed to review communication issue (specifically related to cardiac/respiratory scenarios) and come back to MAG. - agreed

1.2.1 AED in cardiac arrest (Asystole – cease resuscitation). Current published CPG does not include “cease resuscitation criteria”, it was agreed that 1.2.1 will not be used as an assessment sheet until 2nd edition of CPG manual is officially published

1.2.2 AED in cardiac arrest (asystole – continue CPR) – with the publication of the new CPGs this assessment sheet is no longer relevant.

1.4 PEA – differences in opinion on issue of “press to analyse” when recognise a rhythm was expressed. PHECC office agreed to research issue and present back to MAG.

The revised assessment sheets outlined below were presented for approval:

2a – FBAO (conscious adult) & recovery position – “check effectiveness” deleted
Finger sweep... agreed to delete “if object is visualised”. It was also agreed
To include a 3rd critical element on this assessment sheet.

2b – FBAO (infant) & recovery position – it was agreed that “attempt to open airway using tongue jaw lift” should be included as a Critical element.

Note at bottom of sheet should be amended – delete “or” and replace with “and”
to read Up to 5 back blows and chest thrusts in sequence – cease if successful.
To maintain consistency with 2a and 2c a third critical element will be included at
“open airway” in 2b.

2c – FBAO (Conscious child) & recovery position – it was noted that the recovery position for this scenario will be an adult simulated patient.

Recommendation: Assessment sheets – 19.1, 19.2, 1.2.1, 2a, 2b, and 2c be approved subject to changes/modifications outlined above.

Proposed: John Burton

Seconded: Joe Foy

11. AOB

Ms Julie Woods recommended the CPG-A subgroup from MAG be asked to develop assessment sheets for EMT-A examination in line with the CPG-As. Mr Martin O'Reilly recommended inclusion of representatives from both training institutions (NATS and DFB) on this supgroup and it was agreed that Martin O'Reilly would represent DFB on the CPG-A subgroup. It was agreed that the subgroup need to reconvene over the coming weeks to draft the new EMT-A assessment sheets before the next MAG and EMT-A training course.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair



Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Thursday 28th October 2004 at 14:00

Present:

Mark Doyle
John Burton
Mags Bourke
Sean Creamer
Lawrence Kenna
Declan Lonergan
Peter O'Connor
Vincent O'Connor
Martin O'Reilly
Julie Woods

Apologies:

Gerry Bury
Conor Egleston
Fergal Hickey
Macartan Hughes
Cyrus Mobed
Danny O'Regan
Paul Robinson
Tony Ryan
Michael Seaman

In attendance:

Jacqueline Egan, Programme Development Officer
Sharon Gallagher, Support Officer Programme Development
Brian Power, Programme Development Officer

1.0 Chair's business: The Chair referred to 2.1 of previous meeting report which asked for ideas from members on how to improve medical involvement/attendance. He referred to a reply received from Mr Fergal Hickey, Consultant Emergency Medicine, Sligo General Hospital, NWHB who suggested video conferencing as an option. Mr Hickey outlined difficulties in attendance in relation to distance and practicalities of attending on clinic days etc. It was agreed that PHECC would look into video/conferencing access for Consultants and other MAG members for next MAG meeting.

2.0 Meeting Report of the MAG, held at the PHECC Office, Naas on the 29th July 2004 agreed.

Resolution: Meeting Report agreed
Proposed: Martin O'Reilly
Seconded: Sean Creamer

2.1 Matters arising:

The wording of "A&E staff signature" on PRF was highlighted as per previous meeting, Ms Jacqueline Egan outlined that some draft "rewording" of this section on the PRF was in progress and she agreed to circulate to all members.

3.0 EMT-A

Ms Julie Woods distributed a document on the process of assessment for EMT-A. She thanked the Test item writing group and the CPG-A Sub group for their time and contributions in the development of the respected processes. The document outlined the phases of training and assessment, the weighting of each section of assessment as submitted by NATS/UCD, and the draft selection criteria of EMT-A examiners. It was suggested by Dr Mags Bourke and agreed by members to include "spinal injury" into trauma assessment. It was also agreed to have two medication stations; 1) drug dose/calculation 2) drug drawing up and mixing. It was agreed that each OSCE would be of 10 minute duration.

In relation to the draft selection criteria for examiners, it was suggested that the hospital doctors should be at least of post graduate level. It was therefore agreed to amend wording as follows "if a hospital doctor, must be Specialist Registrar Level (SPR)"

Recommendation: EMT-A Assessment document agreed subject to above amendments.

Proposed: Dr Peter O'Connor

Seconded: Declan Lonergan

3.1 CPG-As

Draft version 1.10 were distributed for interim approval in respect to the EMT-A course.

In drug dosages it was agreed to illustrate all dosages in milligrams or millilitres and any dosages less than one milligram to be illustrated as micrograms in brackets afterwards, i.e 0.4 mg (400 mcg).

It was agreed to include a comment in the introduction to the CPG-A manual defining/outlining "consider medical oversight" (wording to be agreed), and therefore to remove any text boxes on individual CPG-As referring to medical oversight.

It was also agreed to remove "sulphate" from all CPG-As.

Adult CPG-As (1-14)

CPG-A 1 Adult Advanced Airway management - agreed.

CPG-A 2 Adult Persistent foreign body airway obstruction - agreed.

CPG-A 3 Adult Inadequate respiration – typo – in bottom text box “consider naloxone....insert “IV/IM” after dose - agreed.

CPG-A 4 Adult Anaphylaxis – “repeat epinephrine (adrenaline)..... to include “at 5 minute intervals” be included on CPG-A

It was also agreed on “Repeat Hartmann’s infusion” to include volume 1,000 ml) - agreed.

CPG-A 5 Adult VF & PVT – It was agreed to amend Lidocaine doses to read “1 - 1.5 mg/kg IV” - agreed.

CPG-A 6 Adult PEA - agreed.

CPG-A 7 Adult Asystole – It was agreed to include “verify” on anlyse rhythm to read “anlyse /verify rhythm” - agreed.

Amend text to read “consider ceasing resuscitation efforts” and refer to new text box on bottom left hand side.

Remove text box “see conditions listed in CPG 3”.

Move text box “if unable to obtain IV access....” To top right hand side beside “advanced airway management”.

Insert new text box on bottom right hand corner to read as follows “cease resuscitation if patient is NOT: hypothermic, cold water drowning, poisoning, overdose, pregnant or <18 years. (as per CPG 3b list)” - agreed.

CPG-A 8 Adult symptomatic bradycardia, remove 2000 mcg in atropine text box - agreed.

CPG-A 9 Adult Cardiac Chest Pain - In the “En route” text box insert “Consider cyclizine 50 mg IV slowly or” and insert brackets around (Ondansetron 4 mg IV)

Delete “(1,200mcg)” from GTN text box at top right. - agreed.

It was noted that PHECC would investigate licencing issues with “Ondansetron”, if its not licenced in any European country then change CPG-A to use Cyclizine.

CPG-A10 Adult Pain management edit as per CPG-A 9 in relation to use of “cyclizine/ondansetron” - agreed.

CPG-A11 Adult Seizures Disorders/Convulsions - In second text box change text to read “ IV access available” – delete “(IM or IO if no access available”

In the text box begining “diazepam 10 mg PR” insert the following line under diazepam “or if inappropriate Lorazepam 4mg IM” - agreed.

CPG-A12 Adult Glycaemic Emergencies - change boxes under “check blood glucose”. First box to read “<4mmol/L” under this box insert text box to read “administer glucose gel”. Second box to read “10 - 20 mmol/L”.

In bottom left hand text box change “consider” to “continue” - agreed.

CPG-A13 Hypovolaemic shock – edit first text box 4th line to read Brain Injury GCS ≤ 13. In bottom text box remove text in brackets after benzylpenicillin (reconstitute each 600 mg....) - agreed.

CPG-A14 spinal immobilisation – - agreed.

Paediatric CPG-As:

CPG-A 50 Asystole/PEA – - agreed.

CPG-A 51 VF & PVT - agreed.

CPG-A 52 Bradycardia - agreed.

CPG-A 53 Hypoglycaemia - In the text box “dextrose ..” include bolus after IV” change format to same as CPG-A 12: insert “if unable to obtain IV access continue glucose gel (check dose) or glucagon 0.5mg (500 mcg) IM, also delete “SC” from this text box. Take out “IO” on contraindicated and insert warning box “do not give glucagon IO” - agreed.

The use of glucagon in children <6 years was discussed and it was agreed that it's administration to children < 6 years would be investigated.

CPG-A 54 Hypovolaemic shock – In benzylpenicillin IV/IO text box remove the following “ (reconstitute each 600mg vial with 4ml water.....over 3-5 min). Amend the next line to read “If IV or IO not attained give dose as above by IM route”.

Delete last sentence in this text box “reconstitute each 600mg vial”

In the features text box change sequence of features of meningococcal sepsis: as follows: history, rash, fever, headache - agreed.

CPA-A 55 Anaphylaxis - agreed.

CPG-A 56 Respiratory distress - agreed.

CPG-A 57 Seizure disorders/convulsions – amend Lorazepam text box to read Diazepam PR first and then as follows - Lorazepam IV 0.1mg/kg repeat after 10 minutes to max dose of 4mg. (if IV access not available consider IM lorazepam)

In following text box change sequence to read “Cool child, if pyrexial...”

- agreed.

CPG-A 58 Severe Pain Management – Delete text box “ consider oral morphine) Insert text box between “assess pain” and “transport and treat” to read “ if pain 2 - 6 minor thermal injury or isolated limb injury consider paracetamol 20mg/kg PO or Ibuprofen 5mg/kg.

In between “assess pain” and “inadequate relief” text boxes insert “ if pain >6”.

In the ondansetron text box edit to read as follows “ Cyclizine 0.7mg/kg IV (max dose – to be confirmed) (Consider Ondansetron)” as with adult CPG-A.

“Wong-Baker faces” reference text font to be reduced in size - agreed.

Resolution: The CPG-As 1 – 14 and CPG-As 50 - 58 be approved as a working draft for 1st Course of EMT-A subject to the agreed amendments.

Proposed by: Dr Peter O’Connor **Seconded by:** Vincent O’Connor

3.2 Medication Formulary:

The Medication formulary to include “class of drug”. Format to be changed in order that it is consistent with format in pharmacology text book which is a prescribed book on the EMT-A course; “Prehospital Emergency Pharmacology”, 5th Edition, Brady, (2005). It was agreed for the licencing and use of ondansetron in pre-hospital care to be explored in the interim. Dr Mags Bourke expressed the need for indications/contraindications for all drugs in the Medication Formulary to be relevant for use only in pre-hospital care.

4.0 Clinical Handbook:

Members were requested to review/proof read the CPG manual for the second time and to forward any issues or queries in writing for amendments to the PHECC Office. All minor or non-critical amendments will be noted for next update.

The issue of launching the Clinical Handbook was noted for further discussion at next MAG.

6.0 Infection Control Guidelines:

The Chair requested members to review the document and to provide feedback to the PHECC office.

**Meeting Report of the PHECC Medical Advisory Group held at the PHECC
office Naas on Thursday January 9th 2003 at 14:00**

Present:

Brian Abbott
John Burton
Sean Creamer
Vincent Cronly
Mark Doyle
Joe Foy
Fergal Hickey
Declan Lonergan
Fergus McCarron
Vincent O'Connor
Michael Seaman

Apologies:

Mags Bourke
Stephen Cusack
Conor Egleston
Mac Hughes
Lawrence Kenna
Paul Robinson
Tony Ryan

In attendance:

Pauline Dempsey
Sharon Gallagher
Brian Power

Issues arising from December's Meeting Report:

7. Attendance on the test item-writing group for EMT-A workshop

It was outlined that

- Mr Cyrus Mobed will represent MAG
- Mr Peter O'Connor will represent OBI /RCSI
- Ms Mags Bourke will represent NATS/UCD

- 6.2** - Ms Pauline Dempsey outlined that the RCSI were investigating fluid replacement pre hospital for adults & children. Any findings will be tabled for consideration by MAG at future meetings.
- The School of Pharmacy, RCSI have reviewed some CPGs for discussion today.
 - It was agreed by the members present that the Medical Advisors were the most appropriate to give medical guidance on the outstanding issues on CPGs. It was put forward that a meeting when all the Medical Advisors could attend, would be planned to resolve the outstanding issues.

2. MAG Meeting Report Dec 6th 2002:

Report agreed.

3. CPGs – New: Draft documents distributed to members.

CPG 1d (BLS Newly born) – it was agreed that Brian Abbott would prepare another draft.

This item was held over for approval at next meeting.

CPG 12a (Behavioural emergencies mentally disturbed) – It was agreed to change mentally disturbed to “Acutely disturbed”.

CPG 12a approved

CPG 12b (Behavioural emergencies aggressive patient)– It was agreed to change aggressive to “Uncooperative”.

This item was held over for approval at next meeting.

CPG 18a (Recognition of death- cessation of resuscitation) – After much discussion it was agreed that at this time, MAG would only prepare a guideline for adult cases of Asystolic arrest. The purpose of which is to empower the EMT to recognise death and discontinue resuscitation efforts. For all other types of cardiac arrest the transport and treat procedure would operate. It was agreed to change title to read “Cessation of resuscitation for asystolic arrest”.

P Dempsey to prepare another draft.

This item was held over for approval at next meeting.

CPG 18b (Recognition of death – resuscitation inappropriate)

It was agreed to delete “gross trauma”, “terminally ill and “advance directive from patient”. Also to change “attending doctor” to “Medical practitioner” It was also agreed to include a fourth condition – “Instructions from person with enduring power of attorney”.

It was agreed to remove all subsequent text boxes and replace with “Inform control, complete appropriate documentation” and “inform relatives”.

A footnote to be included, “Confirmation/certification of death is a medical practitioner’s function”.

P Dempsey to prepare another draft.

This item was held over for approval at next meeting

CPGs 9a, b & c - not discussed

CPG 13b (Entonox)– It was agreed to include “Known otitis media” in the list of contraindications.

CPG 13b approved

CPG 13c (GTN) – It was agreed to remove brand names from this CPG.

CPG 13c approved

CPG 13d (Aspirin)
CPG 13d approved

CPG 13e (Glucose gel) – It was agreed to remove brand names, and under Contraindications, to remove “unconscious patient and conscious patient who has any difficulty breathing”. P Dempsey will clarify the dose with the Pharmacist in the RCSI and will question why it is not suitable for < 2 year olds.

This item was held over for approval at next meeting

The question was raised regarding the authorisation to administer medications according to levels on Register. This has particular significance when medication administration is required and trainees are practicing with personnel who have not done the EMT New Entrant or refresher courses. This issue will need to be addressed.

P Dempsey will prepare a suitable footnote for all pages of the new CPG Manual which may be helpful.

4. Dataset and definitions:

The draft data set and definitions were distributed. Ms Dempsey outlined that this document will continue to evolve to incorporate feedback from the Building Capacity project, from MAG and also to reflect any policy change from the DoHC.

The MAG at this time are asked to approve the data set when satisfied with its content, and recommend it to the Committees and Council for ratification after discussion at the dedicated meeting.

- MAG members are asked to review and email/fax comments to PHECC prior to a dedicated MAG meeting.

The draft data set with definitions was held over for discussion at a dedicated meeting.

5 PHECC Glossary of terms: The draft Glossary of terms was distributed.

MAG members are asked to review the document and email/fax to PHECC any additional terms or comments that members think should be included on Glossary prior to next MAG meeting.

The draft Glossary of terms held over for discussion at next meeting.

6.0 CPG-A's: Draft Version 4 distributed to members.

Only the outstanding issues from previous meeting were discussed.

CPG-A 18 Add Atropine to Paediatric Bradycardia as per AHA/ILCOR, ACLS guidelines.

CPG-A 18 approved

CPG-A 22 Respiratory Distress

CPG-A 22 approved

CPG-A for Pain Management – Adult & Child – not discussed.
Paper from Joe Foy titled “Acute Pain Management for Trauma & transportation” was circulated for information.

CPG-A 8 Symptomatic Bradycardia draft distributed by Declan Lonergan

It was suggested by Fergal Hickey that the “Advanced Cardiac Life Support Guidelines 2002” produced by the Arrhythmia Council in association with the Advanced Cardiac Life Support Council of the Irish Heart Foundation February 2002” be reviewed by all MAG members prior to next MAG. It was suggested that these guidelines could be used as CPG-As. This document will be distributed electronically by PHECC to all MAG members. All CPG-As to be reviewed by members for next MAG.

This item was held over for discussion at next meeting

7. Outline of EMT Training

Outline of EMT training documents were distributed.

It was outlined by Mr Brian Power, that in preparation for the revision of the 1995 Standards, MAG need to advise/agree on minimum approved standards. It was outlined that there is disparity between the Boards’ approaches to the in-service component

A spreadsheet detailing placements by Health Boards was circulated for information. The NEHB and the MWHB updated the hours allocated to classroom training to 16 and 78 hours respectively. The MHB updated the hours for driving to 24 hours.

Recommendation:

The minimum level of training should reflect current practice. This includes 7 weeks pre clinical and 4 weeks supernumerary on an emergency ambulance. A minimum of 100 emergency calls during the in-service component of training with completed PRFs is required.

Proposed by: Sean Creamer

Seconded by: Declan Lonergan, Vincent Cronly, Fergus McCarron

8. AOB

No items

Signed:

Date:

Mr Mark Doyle
Chair MAG



Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Wednesday 26th February 2003 at 10:00

Present:

Brian Abbott
Mags Burke
John Burton
Sean Creamer
Stephen Cusack
Mark Doyle
Noel Flynn
Joe Foy
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Peter O'Connor
Vincent O'Connor
Martin O'Reilly
Michael Seaman

Apologies:

Fergal Hickey
Cyrus Mobed
Tony Ryan
Vincent Cronly
Paul Robinson

In attendance:

Liz Dempsey, Support Officer
Pauline Dempsey, Programme Development Officer
Brian Power, Programme Development Officer
Geoff King (via teleconference), Medical Advisor to PHECC

2. **Meeting Report:** Jan 03 Meeting Report Agreed
3. **PHECC Data set** – discussed as attached
4. **PHECC Glossary of terms** – not discussed
5. **Assessment sheets** – All comments/amendments to be emailed to Mr Brian Power by 4th March. Beyond this date the assessment sheets will be approved and forwarded for consideration at the next Accreditation Committee Meeting.

PHECC'S Medical Advisory Group

Memorandum of meeting report

Held 26th February 2003

Agenda item 3. Data set

PRF data:

Ω PRF number

Patient data:

Ω Name

Ω DOB

Age

Permanent address

Ω Gender

Incident data:

Ω PIN & level on NQEMT register (- C)

Ω Type of call (- C)

Ω Non transported (- C)

Ω Incident location

Ω Type of incident location (- C)

Ω DATE OF CALL

Ω TIME OF CALL

Ω TIME CALL PASSED

Comment [PD1]: New data item

Journey data:

Ω TIME MOBILE

Ω TIME AT SCENE

Ω TIME AT PATIENT

Ω TIME DEPART SCENE

Ω TIME AT DESTINATION

Ω TIME OF HANDOVER

Ω Destination

Ω TIME CLEAR

Incident assessment data:

Primary survey plus

Ω CUPS & AVPU

Vital observations

Ω Patient's chief complaint + time of onset

AMPLE assessment

Ω Mechanism of injury (+ C)

Ω Provider's clinical impression (+C)

Key (-C) = Code only
(+C) = Code in addition to alphabetical entry
Ω = data entered on database
• (Text in blue) guidance notes for completion

Treatment before arrival data:

Ω Nature of assistance (+ C)

Ω Identity of assistance (+ C)

Clinical management data:

Ω Medication treatment (+ C)

Ω Care management interventions (+C)

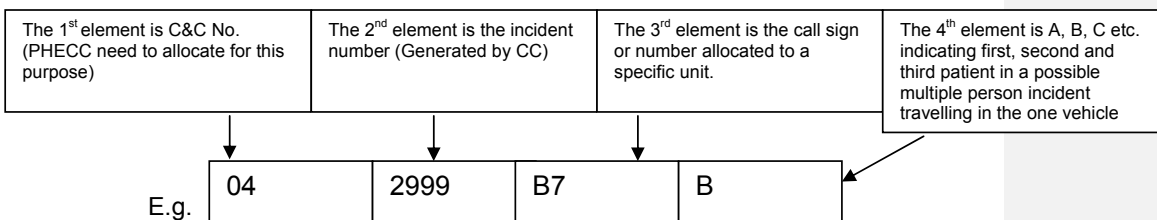
Ω CUPS & AVPU category on handover

Data Element Number	1.
Name of Data Element:	PRF number
Definition:	Unique identifier for the patient and case
Entry:	Alphabetical and numerical entry
Domain:	Efficiency

Comment [PD2]: For review - Other options welcome.
-serial No. on hard copy (problematic for electronic capture and where 2 or more stationary suppliers are involved)
-

Discussion: The number constitutes 4 separate elements to create one unique number.

Comment [PD3]: NEHB have good experience of 4th element



- Complete all fields

Data Element Number	2.
Name of Data Element:	Patient name and surname
Definition:	Title by which a patient is known. First name followed by surname
Entry:	Alphabetical entry
Domain:	Quality of care

Comment [PD4]: No standard in hospitals regarding which name comes first

Discussion: To enable healthcare team address patient by name and record details of care and treatment provided on patient report form specific to that patient.

- Enter name, if unavailable record U in both fields as appropriate

Comment [PD5]: To note that a name as an identifier is less reliable now than in the past

Data Element Number	3.
Name of Data Element:	D.O.B.
Definition:	Specific day, month and year the patient was born
Entry:	Numeric entry DD.MM.YYYY (2 +2 + 4 characters per field)
Domain:	Quality of care

Discussion: Demographic detail for identification purposes. Also enables accurate age assessment particularly for children which can impact on care.

- Enter DOB, if unavailable record U in fields as appropriate

Data Element Number	4.
Name of Data Element:	Age estimate
Definition:	Approximate age when D.O.B. is unknown. In days, weeks months and or years
Entry:	Numerical entry
Domain:	Quality of care

Comment [PD6]: Add in weeks months and years

Discussion: Demographic detail for identification purposes. This section only needs to be filled in if the D.O.B. is not available

- Enter age estimate in weeks, months or years as appropriate. E.g. 2 week (baby), an 8 month (infant), a 22 years old

Data Element Number	5.
Name of Data Element:	Permanent address
Definition:	Location of where the patient has permanent residence
Entry:	Alphabetical entry
Domain:	Quality of care

Comment [PD7]: Replace home address with permanent address.

Discussion: Demographic detail for identification purposes. As much detail as is known should be recorded. Patient's usual place of residence should be recorded. Other significant addresses such as for those on holidays or in temporary accommodation can be recorded under Additional Information.

- Enter address, if unavailable record U in field as appropriate

Data Element Number	6.
Name of Data Element:	Gender
Definition:	Classification of being male or female
Entry:	Alphabetical entry, use abbreviations M/F
Domain:	Patient identification

Comment [PD8]: Remove U

Discussion: Demographic detail for identification purposes.

- Enter M/F in field as appropriate

Data Element Number	7.
Name of Data Element:	PIN & NQEMT level on PHECC register
Definition:	Identification of NQEMT responders engaged in care of patient pre hospital. Plus level of NQEMT on Register of all attending crew
Entry:	PIN & code -select one from list
Domain:	Efficiency

Comment [PD9]: PIN ok
Level on register -for discussion again.
Options welcome

Discussion: Identity of the crew who managed the case ensures that the PRF is a true and accurate account of events. Examined with patients chief complaint and providers clinical impression it permits assessing the level of care available from the EMS response. Purpose to examine deficits in service or training/skills available. Or can be used to target need for EMT - A or Medical support in a particular clinical situation.

- Enter your PHECC issued personal identity no. (PIN)
- Enter correct code that corresponds to your skill level on the PHECC Register.

NQEMT EMFR

NQEMT EMT

NQEMT EMT T

NQEMT EMT-A

NQEMT EMT-A Intern

Other to include generic code for 1. Student nurse 2. Visitor/observer etc.

Data Element Number	8.
Name of Data Element:	Type of call
Definition:	Type of call determined by the attending crew after the primary survey
Entry:	Code - Select from list
Domain:	Incident information

Comment [PD10]:
 -Look at other categories types.
 -Reconsider meanings of codes
 Office to review

Comment [PD11]: New title

Discussion: Facilitates audit to compare what priority dispatch the Communication Centre gave the call compared to what the attending crews allocate after completion of the primary survey.

- Enter correct code from list

TCA Presenting condition which may be immediately life threatening.
 TCB Presenting condition which though serious, is not immediately life threatening.
 TCC Presenting condition which is not immediately life threatening or serious.

Data Element Number	9.
Name of Data Element:	Non transported
Definition:	Indicates disposition where a patient is not transported following the activation of an emergency ambulance
Entry:	Code - Select from list
Domain:	Efficiency

Comment [PD12]:
 Decided that code for use only where there is patient contact

Discussion:

- Enter correct code from list

NT1 Recognition of death at scene not transported
 NT2 Treatment and or transport refused against advice
 NT3 Treatment at scene and no requirement for transportation

Data Element Number	10.
Name of Data Element:	Incident location
Definition:	Address of where the emergency ambulance is dispatched in response to an emergency call
Entry:	Alphabetical entry
Domain:	Incident information

Comment [PD13]:
 -Discussed was the merit in pin pointing the exact location if a patient were moved pre arrival.
 -Agreed was that it is address at which the incident happened.
 -In any suspicious circumstances where the crew would like to record that a patient was moved this can be done under Additional Information.
 -Also if it is important to record that the patient was found outside or inside can be facilitated under Additional Information.
 - GPS options and availability?

Discussion: Assists in assessing the appropriateness of response times and can be used to determine/audit the appropriate level of emergency ambulance resources for specific areas.

- [Enter appropriate address.](#)

Data Element Number	11.
Name of Data Element:	Type of incident location
Definition:	Type of incident location - where the incident happened
Entry:	Code - Select from list
Domain:	Incident information

Comment [PD14]: Definition for - GPS options and availability? clarification
 -code the location where the incident happened not where patient found (should s/he be moved)

Discussion: This data item is of interest to epidemiologists as well as EMS planners to study trends and ensure the correct location of resources.

- [Enter correct code from list](#)

International Classification of Diseases, 9th Revision.
ICD-9.WHO, Geneva.

E849 Place of occurrence

- E849.0 Home
- E849.1 Farm
- E849.2 Mine and quarry
- E849.3 Industrial place and premises
- E849.4 Place for recreation and sport
- E849.5 Street and road
- E849.6 Public building
- E849.7 Residential institution
- E849.8 Other specified places

Data Element Number	12.
Name of Data Element:	DATE OF CALL
Definition:	Specific day, month and year the call is received. Recorded at and by the Communication Centre (CC)
Entry:	Numerical entry DD.MM.YYYY (2 +2 + 4 characters per field)
Domain:	Efficiency

Comment [PD15]: Agreed as an essential item on the data set

Comment [PD16]: Is it a requirement on the PRF?

Discussion: Date of call relates to the time the emergency call is received at CC, e.g. 23:55 on 31.10.2002 but not dispatched until 00:05 on 01.11.2002 the date recorded is 31.10.2002.

It means in effect the date the incident occurred. Permits planning to allocate resources by day of week and month etc. and permits sorting for statistical purposes. DATE AND TIME OF CALL received by CC is required to calculate Activation and Response times

- Enter date of call that is provided from CC.

Data Element Number	13.
Name of Data Element:	TIME OF CALL
Definition:	The time recorded at the precise time when the call is answered by a call taker. Recorded at and by the CC
Entry:	Numerical entry 24hr clock HH:MM.SS
Domain:	Efficiency

Comment [PD17]: Discussed by MAG was the merit in having the crews record this data item on the PRF.
-Is it a requirement on the PRF?
-Agreed that it is essential element of the data set.

Comment [PD18]: Details such as confirmation of Tel no, exact location and nature of chief complaint are considered call interrogation and should not be confirmed prior to recording time of call.

Comment [PD19]: Seconds are a requirement in UK for accurate response standards measurement, ditto for all times measured.
-Is there capacity to measure seconds in CC Ire?

Discussion: Time is given by CC to crew. TIME OF CALL required with TIME MOBILE to calculate Activation Time. Required with TIME AT SCENE and TIME AT PATIENT to calculate Response Times

- Enter time of call that is provided by CC

Data Element Number	14.
Name of Data Element:	TIME PASSED
Definition:	The time the dispatch details of the emergency call was passed to the crew
Entry:	Numerical entry 24hr clock HH:MM.SS
Domain:	Efficiency

Comment [PD20]: New data item

Comment [PD21]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Though not an element to calculate either activation or response times it is important to determine TIME PASSED, to emphasis the clinical importance of the series of times recorded and any delays in dispatch.

- [Enter time the call is received by the attending ambulance crew.](#)

Data Element Number	15.
Name of Data Element:	TIME MOBILE
Definition:	Time the emergency ambulance/vehicle with appropriate crew, mobile (on dispatch) on way to scene
Entry:	Numerical entry 24 hr clock HH:MM.SS
Domain:	Efficiency

Comment [PD22]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Required with DATE AND TIME OF CALL to calculate Activation time.

- [Enter time mobile](#)

Data Element Number	16.
Name of Data Element:	TIME AT SCENE
Definition:	Time of arrival of emergency ambulance/ vehicle at scene
Entry:	Numerical entry 24 hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD23]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Required with DATE AND TIME OF CALL to calculate Response time

- [Enter time at scene](#)

Data Element Number	17.
Name of Data Element:	TIME AT PATIENT
Definition:	Time of arrival at patient side to provide immediate care
Entry:	Numerical entry 24hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD24]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Compare with TIME AT SCENE to determine time in arriving at patient's side. This prompts audit of environmental factors over which the ambulance service often have no control. Required to calculate Patient care time

- [Enter time at patient](#)

Data Element Number	18.
Name of Data Element:	TIME DEPART SCENE
Definition:	Time the patient departs the scene to travel to destination
Entry:	Numerical entry 24 hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD25]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Permits the calculation of the travel time from scene to destination point/hospital. Also permits calculation of the actual time at scene

- [Enter time depart scene](#)

Data Element Number	19.
Name of Data Element:	TIME AT DESTINATION POINT/hospital
Definition:	Time patient arrives at hospital or other destination
Entry:	Numerical entry 24 hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD26]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Permits the calculation of travel time from scene to destination point/hospital. Used with TIME AT PATIENT to calculate Patient care time

- [Enter time at destination](#)

Comment [PD27]: For discussion - that TIME OF HANDOVER could be used as an element to calculate Patient care time rather than TIME AT DESTINATION

Data Element Number	20.
Name of Data Element:	TIME OF HANDOVER
Definition:	Time of completed handover of patient to another member of the healthcare team at the destination point/hospital
Entry:	Numerical entry 24 hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD28]: See point above. When does patient care time end? At data element 19. or 20.?

Discussion: Will permit the calculation of time spent at hospitals and any delays in transferring care to the health care team.

- Enter time of handover

Data Element Number	21.
Name of Data Element:	Destination
Definition:	Name of destination point /hospital or other facility
Entry:	Alphabetical entry
Domain:	Efficiency

Comment [PD29]: For discussion -how much detail is required eg hospital only or - extend to include exact department in the hosp.

Discussion: Can estimate the percentage of transports to specific destination points/ hospitals. May include Afterhours GP Co-ops, minor casualties units etc. in the future.

- Enter name of destination point/ hospital

Data Element Number	22.
Name of Data Element:	TIME CLEAR
Definition:	Time vehicle, crew and equipment available for next dispatch
Entry:	Numerical 24 hr clock HH:MM:SS
Domain:	Efficiency

Comment [PD30]: Seconds are a requirement in UK for measuring accurate response standards,

Discussion: Allows planning of emergency ambulance services and permits assessment of the delays incurred at destination point.

- [Enter time clear](#)

Data Element Number	23.
Name of Data Element:	Primary survey
Definition:	A summary of injuries or abnormal findings to include AVPU and CUPS categories
Entry:	Alphabetical entry for summary C, U, P or S select one category A, V, P or U select one category
Domain:	Patient health outcome

Comment [PD31]: Agreed to remove time element (same as time at patient)

Discussion: Permits analysis of use of emergency ambulance service and selection of appropriate CPG in response to patient's presentation.

- [Enter summary of primary survey](#)

Airway	Clear Obstruction
C Spine	Not indicated Suspect
Breathing	Normal Absent Abnormal Rate and effort
Circulation	Skin colour and perfusion Pulse rate and regularity Cap refill Haemorrhage Y or N

Comment [PD32]: Wording of options under primary survey for discussion

- [Enter AVPU and CUPS category based on primary survey.](#)

Data Element Number	24.
Name of Data Element:	Vital observations + times recorded
Definition:	A record of the physical assessment of the patient incl.: Cardiovascular system Respiratory system Endocrine system Neurological system etc. As required.
Entry:	Numerical entry on vital observation sheet
Domain:	patient health outcomes

Discussion: Gives base line evidence of how a patient presents and will highlight deterioration and /or improvement in response to immediate care provided and throughout the journey to destination point/ hospital.

- Enter vital signs recorded as appropriate on the vital observation sheet

Data Element Number	25.
Name of Data Element:	Patients chief complaint + time of onset/occurrence
Definition:	Primary presentation. The reason why the patient is seeking medical care and the services of the emergency ambulance were called 999/112
Entry:	Alphabetical and numerical entry
Domain:	Patient health outcome

Comment [PD33]: Add chief

Discussion: As described/indicated by the patient or if information unavailable, observed by a bystander including family of what precipitated calling an emergency ambulance/vehicle. If patient has more than one complaint list in order of distress to patient. Permits analysis of the use of ambulance services.

- Enter patients complaint and time of onset/occurrence, if unavailable record U.

Data Element Number	26.
Name of Data Element:	“ A” Allergies
Definition:	Reported known drug and agent allergies of patient
Entry:	Alphabetical entry
Domain:	Patient health outcomes

Discussion: Known drug sensitivities will highlight contra indication of certain drugs or groups of drugs. May also indicate a cause of anaphylaxis if history suggestive of exposure to an agent.

- Enter a list of allergies, if unavailable record unknown U

Data Element Number	27.
Name of Data Element:	“M” Medications
Definition:	List of medications patient takes regularly
Entry:	Alphabetical entry
Domain:	Patient health outcomes

Discussion: Compliance with medication should be ascertained. It could have an impact on chief complaint if the routine tablets have not been taken. E.g. daily warfarin, or insulin dependent diabetes who have skipped a meal etc...

Mandatory for EMTs own practice to establish if patient is on any medications that may interact with any as per CPG that may be considered prior to administration.

- Enter a complete a list of medications if a manageable number,
- Or record “per supplied” to mean medications collected and brought to ED,
- Or as “per Dr. letter” if available.

Data Element Number	28.
Name of Data Element:	“P” Pertinent medical history
Definition:	Relevant medical history reported by patient or next of kin or noted on assessment
Entry:	Alphabetical entry
Domain:	Patient health outcome

Discussion: Record only the pertinent history to the condition presenting. This can often provide the background to the current medical complaint and can act as an aid in the selection of CPG.

- Enter pertinent history, if unavailable record unknown U.
- If no pertinent medical history, record None.

Data Element Number	29.
Name of Data Element:	“L” Last oral intake
Definition:	Record of time of last food or drink taken
Entry:	Numerical 24 hr clock HH:MM
Domain:	Patient health outcome

Discussion: Useful in considering potential airway problems. This can have significant clinical importance particularly in a patient with an altered level of consciousness and also during transport.

- Enter time of last intake, if unavailable record U.

Data Element Number	30.
Name of Data Element:	“E” Events leading up to incident
Definition:	Summary of what happened immediately prior to incident/injury occurring
Entry:	Alphabetical entry
Domain:	Patient health outcomes

Comment [PD34]: AMPLE agreed

Discussion: Can correlate the injury/illness with any precipitating events. E.g. ?LOC before or after the fall.

- Enter summary of events, if unavailable record U.

Data Element Number	31.
Name of Data Element:	Mechanism of injury
Definition:	Category of external cause of trauma
Entry:	Alphabetical entry & Code -Select from list
Domain:	Patient health outcome

Discussion: Recording the external causes of trauma, permits an audit of factors which can precipitate trauma. This may contribute to accident prevention and in accident kinematics.

Kinematics - a principle in physics which enables assessment of possible injuries resulting from the study of forces and motion.

- Enter mechanism of injury and correct code from list.

International Classification of Diseases, 9th Revision ICD-9.WHO, Geneva.

EXTERNAL CAUSES OF INJURY

E81x.x	Motor vehicle traffic accident
E814.x	Pedestrian traffic accident
E82x.x	Motor vehicle non-traffic accident
E826.x	Bicycle accident
E83x.x	Water transport accident
E84x.x	Aircraft related accident
E86x.x	Accidental chemical poisoning
E88x.x	Accidental falls
E906.9	Attack by animal
E89x.x	Fire and flames
E89x.2	Smoke inhalation
E900.x	Excessive heat
E901.x	Excessive cold
E905.x	Venomous stings (plants, animals)
E907.x	Lightning
E910.x	Drowning
E913.x	Mechanical suffocation
E919.x	Machinery accidents
E925.x	Electrocution (non-lightning)
E926.x	Radiation exposure
E985.x	Firearm injury (accidental)
E965.x	Firearm assault
E955.x	Firearm self inflicted (intentional)
E960.1	Rape
E967.x	Non accidental injury to children
E000.00	Not applicable (where no mechanism of injury; no trauma)
E960.00	Assault

Comment [PD35]: Discussed was that there is scope that this list is amended over time as the data collection experience grows.

Data Element Number	32.
Name of Data Element:	Provider's clinical impression
Definition:	An early clinical impression of what is the presenting illness/injury based on the information available
Entry:	Alphabetical entry & Code - Select from list.
Domain:	Patient health outcome

Comment [PD36]: To consider other options to this title. Other option welcome from MAG

Discussion: Information gathered from the patient and scene, evaluated and synthesized facilitates the implementation of appropriate CPGs in response to the patient's presentation. Also permits analysis of the use of ambulance services; appropriate vs. inappropriate, and assessment of immediate care provided compared to presenting condition

- Enter your clinical impression and correct code from list. . Note if 959.90 (traumatic injury) is selected then write the injury or injuries sustained as free text. E.g. # femur.
- When no code is available from the list to suit the patient, enter in text what best describes the patient and during the annual review the codes will be modified by the MAG.

International Classification of Diseases, 9th Revision. ICD-9.WHO, Geneva.

789.00 Abdominal pain/problems
519.80 Airway obstruction
995.30 Allergic reaction
780.09 Altered level of consciousness
724.5 Backache
949.XX Burns (unspecific)
312.90 Behavioural/psychiatric disorder
427.50 Cardiac arrest
427.90 Cardiac rhythm disturbance
786.50 Chest pain/discomfort
250.90 Diabetic symptoms
994.80 Electrocutation
780.60 Fever/pyrexia
784.0 Headache
780.60 Hyperthermia
780.90 Hypothermia
785.59 Hypovolemia/shock
987.90 Inhalation injury (toxic gas)
798.99 Obvious death
977.90 Poisoning/drug ingestion
659.90 Pregnancy/OB delivery
799.10 Respiratory arrest

Comment [PD37]: Potential that this list is amended over time as data collection experience grows

786.09	Respiratory distress
780.30	Seizure
959.90	Sexual assault/rape
987.90	Smoke inhalation
989.50	Stings/venomous bites
436.00	Stroke/CVA
780.20	Syncope/collapse
959.90	Traumatic injury
623.80	Vaginal haemorrhage

Data Element Number	33.
Name of Data Element:	Nature of assistance before arrival
Definition:	Help or support by another before the arrival of the emergency ambulance service
Entry:	Alphabetical entry & Code -Select from list
Domain:	Patient health outcome

Comment [PD38]: Title amended

Discussion: This code permits measurement of community education and skills in first aid and BLS. The EMT is to assess, where possible, whether the first assistance demonstrated appropriate technique.

- Enter the nature of assistance before arrival and correct code from list.

Comment [PD39]: Agreed by MAG that it was valuable to have EMTs evaluating the first assistance available

NA0	None
NA1	First aid attempted
NA2	First aid appropriate technique
NA3	BLS attempted
NA4	BLS appropriate technique
NA5	BLS & AED use

Data Element Number	34.
Name of Data Element:	Identity of assistance
Definition:	Identity of first responder i.e. the person providing assistance to the injured or ill patient prior to the arrival of the emergency ambulance service.
Entry:	Alphabetical entry & Code -Select from list
Domain:	Patient health outcome

Comment [PD40]: Out of the data elements 33 and 34 a discussion arose regarding -the option of having *others at scene* as an additional data item

Discussion: Facilitates audit of care and management appropriate to presenting condition. Of particular interest to Public access defibrillation, and first responder

models in certain communities. Coding permits assessment of community education in first aid and actual skills.

- [Enter identity of first assistance and correct code from list.](#)

IA0 None
 IA1 Doctor
 IA2 Garda
 IA3 Fire Services
 IA4 Nurse
 IA5 Lay person (including family)
 IA6 NQEMT - EMFR
 IA7 Voluntary Services
 IA8 Occupational First Aider
 IA9 EMT

Data Element Number	35.
Name of Data Element:	Medication treatment
Definition:	List of medication treatment provided. Name, time given, dose and route, PIN of NQEMT holder
Entry:	Alphabetical entry & Code -Select from list
Domain:	Patient health outcomes

Discussion: A legal requirement that medications administered are recorded and signed for. Permits assessment of medication treatment provided appropriate to presenting condition.

- [Enter medication given and code from list](#)

AG Aspirin (given)
 AC Aspirin (contraindicated)
 O₂ Oxygen
 EN Entonox
 GG Glucose Gel
 GT GTN
 AT Atropine
 BZ Benzylpenicillin
 ST Stesolid
 DI Diazepam
 AD Adrenaline
 GL Glucagon
 AM Amiodarone
 MS Morphine Sulphate

 NX Naloxone
 CZ Cyclizine

SA Salbutamol
 HF Heparin flush

 HA Hartmann's Solution
 SC Sodium Chloride 0.9%
 DX Dextrose 10%
 DR Other drug/fluid administered by Dr.

Comment [PD41]: This list will be added to as the CPG s and Medication formulary are further developed.

Data Element Number	36.
Name of Data Element:	Care management interventions
Definition:	Record of immediate care provided pre hospital
Entry:	Alphabetical entry & Code -Select from list
Domain:	Patient health outcomes

Discussion: Accurate clinical record keeping of care provided has a positive influence on the continuum of care for patients. This facilitates the assessment of care management provided and use of equipment/CPGs appropriate to presenting condition and the provider's clinical impression. In addition it provides information about what care management interventions /procedures are available pre hospital and for what indications. T is useful in providing evidence for training and development needs.

- Enter care management interventions and code from list. In many cases there may be multiple codes used.

Airway/Breathing

- 01 Manoeuvre
- 02 Suction
- 03 Manual clearance
- 04 OPA
- 05 NPA
- 06 LMA
- 07 Pocket mask
- 08 BVM +O₂
- 09 Simple facemask
- 10 Venturi mask
- 11 Non-re breather mask
- 12 Nasal cannula
- 13 O₂ and flow rate
- 14 FB clearance
- 15 Intubation

Immobilisation/Extrication

- 20 Cervical collar
- 21 Spinal board
- 22 Vacuum

- 23 Splint
- 24 Traction splint
- 25 Vacuum mattress
- 26 Box splint
- 27 Inflatable splint
- 28 Frac straps
- 29 Sam splints
- 30 Extrication device

Cardiac Support

- 30 ECG monitoring
- 31 12 lead ECG transmission
- 32 Defibrillation
- 33 Chest compressions

Miscellaneous

- 40 Haemorrhage control
- 41 Minor injury treatment
- 42 Reassurance
- 43 Advice
- 44 Positioning
- 45 Burns dressing
- 46 Other dressing
- 47 Treatment declined

Cannulation

- 50 Intravenous cannula
- 51 Intraosseous needle

Other procedures

- 61 Needle thoracocentesis

Comment [PD42]: A number of amendments were made after discussion at MAG
-This list will expand in line with guidelines

Data Element Number	37.
Name of Data Element:	CUPS & AVPU category on handover
Definition:	Based on CUPS and AVPU classifications
Entry:	Alphabetical entry C, U, P or S select one category A, V, P or U select one category
Domain:	Patient health outcome

Comment [PD43]: Agreed

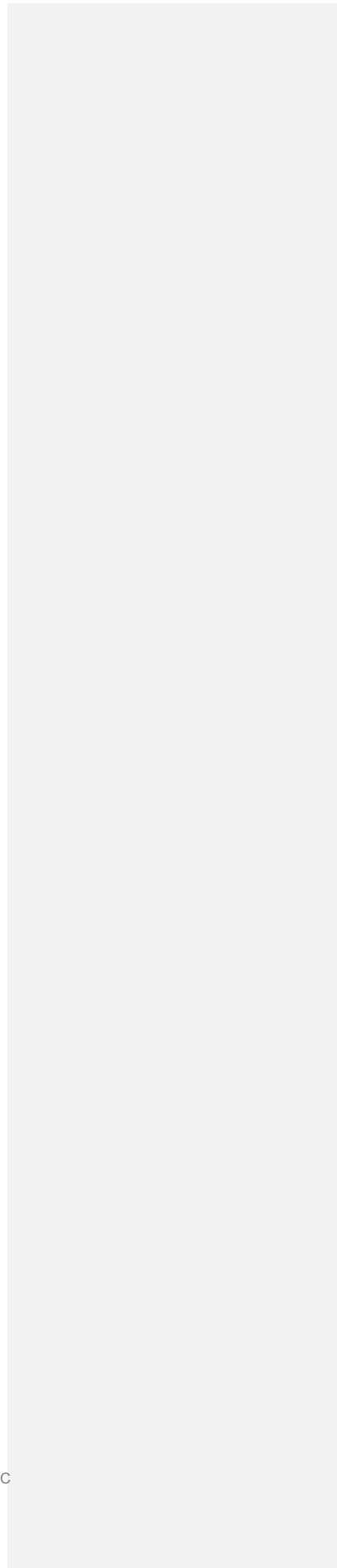
Discussion: Enables a comparison to earlier injury assessment as the emergency ambulance arrived. Permits reflection on status prior to handover to acute hospital services in the continuum of care.

- Enter category of CUPS & AVPU as appropriate

Signed :

Date:

Mr Mark Doyle
Chair MAG





**Meeting Report of the PHECC Medical Advisory Group
held at the PHECC office Naas on Wednesday 23rd April 2003 at 10:00**

Present:

John Burton
Mark Doyle
Joe Foy
Macartan Hughes
Lawrence Kenna
Vincent O'Connor

Apologies:

Brian Abbott
Mags Burke
Sean Creamer
Stephen Cusack
Conor Egleston
Fergal Hickey
Declan Lonergan
Cyrus Mobed
Martin O'Reilly
Patrick Plunkett
Tony Ryan
Michael Seaman

In attendance:

John Beecher, Consultant
Pauline Dempsey, Programme Development Officer
Sharon Gallagher, Support Officer
Brian Power, Programme Development Officer

2. Meeting Report: Feb 03 Meeting Report agreed.

Resolution: It was agreed by MAG to forward the draft data set to the Clinical Care Committee for further discussion.

3. CPGs:

3.1 CPG 1d BLS Newly Born – After “assess colour “replace with 2 boxes coming from arrows from “colour pink – give baby to Mum”, First box to read “if persistent central cyanosis ventilate with BVM 100%”.

Arrow over to second box “Consider free flow 100% O₂ if peripheral cyanosis” Arrow to “transport and treat” box.

1d agreed

3.2 CPG 3a Cardiac Arrest – change blue text box at bottom of 3rd column to read “Asystolic decision tree (See CPG 3b)”

Arrow from this text box to new box reading “Patient is

- Hypothermic or
- Cold Water drowning or
- Poisoning or
- Overdose or
- Pregnant or
- <18 years or
- Time to ACLS intervention < 15 mins

Arrow from this if “Yes” to “transport and treat”.

Arrow from this if “No” to “go to CPG 3b”

3a agreed

3.3 CPG 18A – renamed to 3b – Cardiac Arrest Asystole –decision tree.

Text box amended to read:

“Patient is – Hypothermic or

- Cold Water drowning or
- Poisoning or
- Overdose or
- Pregnant or
- <18 years or
- Time to ACLS intervention < 15 mins

In “Confirm asystolic cardiac arrest” text box amend text to read:

- “unresponsive
- no signs of life; absence of central pulse and respiration
- Asystole on ECG monitor”

CPG 3b agreed

3.4 CPG 12b – Behavioural Emergency – Uncooperative patient

Remove black text box “provider’s clinical impression...” and amend following blue box to read:

Assess potential to harm self or others

- Reassure patient
- Explain what is happening at all times
- Avoid confrontation

Insert new text box to read “Patient agrees to travel” with arrows “yes” and “no”

“Yes” arrow goes to “Transport and Treat” text box and “Go to CPG 15a”

“No” arrow goes to text box “injury or illness potentially serious or likely to cause lasting disability. Insert 2 arrows “yes” and “no” from this text box.

“Yes” arrow goes to “Request Control to inform Garda” and continues to text box “Inform patient of potential....”

“No” arrow goes directly to “inform patient of potential...”

Delete text box “patient is fully lucid...” and split text box “advise alternative care option...” to two boxes.

First box to read “Advise alternative care options and to call ambulance again if changes mind”

Arrow to Second box to read: “Document & have witnessed options given to patient & refusal.”

Delete bottom text box “Contact: Medical Practitioner...”

CPG 12b agreed – Directions for Control will need to be addressed.

3.5 CPG 13e – Glucose gel

In first sentence amend to read “Presentation: Glucose gel” (delete “in a tube or sachet”). In blue text box include the following text “GCS<15” above “administer glucose gel”

In second blue text box amend **Dose** to read “10-20g glucose. Repeated in 5-10 minutes as required to maintain BGL \geq 4.0mmol.”

Amend red “effects” text box to read:

“Effects: - Raise blood glucose levels

Contraindications – None”

CPG 13e agreed

3.6 CPG – 18b – renamed to 17a Recognition of death Resuscitation not indicated

Amend list of “Obvious death” to read

- Decomposition
- Rigor mortis
- Incineration
- Decapitation
- Pooling
- Other injuries totally incompatible with life. Document with two 30 secs.

Rhythm strips

Delete points 2, 3 & 4.

CPG 17a agreed

3.7 CPG 19a – Hypothermia

It was recommended that these points are assimilated into an information box on the CPG 1a.

– References for Hypothermia need to be reviewed using ILCOR 2001 Guidelines

4. Meningitis Research Foundation – Guidelines were distributed on

Meningococcal disease: identification & management for EMTs.

The group indicated that they are in favor of considering submissions for PHECC endorsement from Patient Representative Groups or other organisations that may be from time to time sent to PHECC.

Resolution: It was agreed by MAG to forward this issue and endorsement issues in general to the Clinical Care Committee.

5. Medication formulary – This remains work in progress between the School of Pharmacy RCSI and the PHECC office. See *point 6.2 below*.

6. AOB

– It was suggested by Mr. Joe Foy that PHECC could prepare regular guidelines or bulletins for the Ambulance Services on the pre hospital management of patients with infectious diseases.

Resolution: It was agreed by MAG to forward issue to Clinical Care Committee for further discussion.

CPG-As: A discussion ensued regarding the number of outstanding CPG-As.

Resolution: It was agreed by MAG that the sub-group created for the review and development of CPG-As in October last for the revision of the draft CPG-As should reconvene again. The medication formulary would also be reviewed by this group.

MIMMS – The issue of MAG endorsing MIMMs principles as the standard of training in Ireland in relation to Major Emergencies/Incidents was discussed.

Resolution: It was agreed by MAG to forward this issue to Accreditation and Clinical Care Committees for further discussion.

Mr. Cyrus Mobed made an enquiry through the PHECC office to the MAG regarding the issue of oxygen administration for COPD patients. This has arisen following a critical incident with a patient in the MHB. A group of medical practitioners in the MHB, had contacted him and indicated that they were interested in preparing a CPG for use in the Ambulance Services on that topic.

Resolution: It was agreed by MAG that submissions in relation to pre - hospital clinical care are welcome from any source but should be made to the Director of the PHECC for consideration.

CPG subgroup- It was agreed that a subgroup of MAG will meet to review the draft CPGs for critical content and for proof reading. The following members agreed to participate in the subgroup: Mr. Mark Doyle, Mr. John Burton, Mr. Martin O'Reilly (to be notified) and Ms Pauline Dempsey.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair



Meeting Report of the PHECC Medical Advisory Group held at the PHECC office Naas on Thursday 23rd October 2003 at 10:00

Present:

John Burton
Sean Creamer
Mark Doyle
Joe Foy
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Cyrus Mobed
Martin O'Reilly
Michael Seaman

Apologies:

Brian Abbott
Mags Bourke
Stephen Cusack
Conor Egleston
Tony Ryan
Fergal Hickey
Macartan Hughes
Peter O'Connor
Vincent O'Connor
Patrick Plunkett
Paul Robinson

In attendance:

Liz Dempsey, Support Officer Programme Development
Pauline Dempsey, Programme Development Officer
Geoff King, Director
Brian Power, Programme Development Officer

1.0 Chair's business and matters arising from April's meeting report:

April '03 Meeting Report agreed.

1.1 Decisions from Clinical Care Committee, July 2003.

The question of Council endorsing the Meningitis Research Foundation guidelines will be addressed by Council at an appropriate meeting.

1.2 The matter of Council endorsing the principles of the MIMMS course for use in training programmes, examinations and CPGs will be addressed by Council at an appropriate meeting. The Director will contact the MIMMS group in the UK and begin discussion with them.

1.3 For information, the CCC resolution in July 2003 regarding the issuing of infection control bulletins was “Clinical Care members considered this issue would be unnecessarily duplicating the role of the Public Health agencies already involved”.

1.4 Organisational approval process for CPGs

A handout was tabled “CPG approval process” for discussion by the MAG. The Director, sought guidance from MAG on the draft proposal which when finalised will be a process whereby Statutory ambulance services sign up to CPGs and other pre-hospital emergency care providers apply for Councils approval to use CPGs in their organisations. Criteria for approval were discussed. The suggestion was made by Martin O’ Reilly that having access to a Medical Advisor could be added to the list of criteria. Other suggestions from the group will be included and a paper would be prepared for consideration at the next meeting.

Resolutions:

1. That Councils approval be sought for a process that requires Health Boards and DFB to sign off acknowledging receipt and commitment to CPGs for implementation in their ambulance services.

2. That Council approval be sought for a process that requires other pre-hospital emergency care providers to apply for approval from PHECC to implement all or selected CPGs in their services.

Moved: Declan Lonergan
Carried without dissent

Seconded: Fergus Mc Carron

1.5 HeBE and SOPs

The Director advised that HeBE is looking at a project to prepare operational SOPs. MAG will continue to manage CPGs, staying with clinical issues and HeBE will link in with PHECC as appropriate during SOP development. It was agreed that PHECC will keep the MAG informed on any progress.

1.6 Cardiac re-certification for EMTs

The issue was raised as to whether PHECC should establish a standard of training for using an AED in the community and in the statutory services. Programme Development Officer, Brian Power highlighted that there has been no standards formally approved in the ambulance service, only custom and practice. Martin O’Reilly explained that DFB recertify every 3-6 months. Declan Lonergan highlighted that the Health Board EMTs recertify once a year. The need to establish the level of competence required for the AED re-certification person was also identified. There may be a need to have two streams – EMT level and public access level.

There was general support from MAG that this issue needed to be addressed.

The Director suggested the office would develop a matrix for the frequency and content of training as well as required competencies of trainer reflecting

NATS/DFB and the AHA guidelines/standards. A paper for consideration by MAG members would be prepared for the next meeting.

2. CPGs (37) for final approval:

It was agreed to move all information/explanatory boxes to an appropriate appendix in the CPG manual.

CPG 1a – Change text in final text box to read “where severe hypothermia is suspected. Delete “Apply cardiac monitoring” and replace with “if VF defibrillate up to a maximum of three shocks and continue to monitor. 1a approved.

CPG 1b – Approved. It was agreed that MAG will review the ILCOR guidelines on use of AED for children in the future.

CPG 1c – Approved.

CPG 1d – Approved.

CPG 2a – Approved.

CPG 2b – Approved.

CPG 2c – Approved.

CPG 3a – Change title to “Automated External Defibrillator”. Delete text “No pulse or respirations” from the first box on CPG. Change text from “MAX – 12 shocks” to “Max – 12 shocks per episode”. 3a approved.

CPG 3b – Change text in box to read “Confirm one minute of CPR and “no shock advised” x 3 are completed. 3b approved.

CPG 4a – Approved.

CPG 4b – Approved.

CPG 5a – Delete “NB- examine palpate....”. 5a approved.

CPG 5b – Delete “NB- examine palpate....”. 5b approved.

CPG 6a – Move the entire guideline to Appendix.

CPG 7a – Approved.

CPG 7b – Approved.

CPG 7c – Approved.

CPG 8a – Delete “Physiological findings” from text box. 8a approved.

CPG 9a – Change text in box to read “Contact GP/midwife/medical team as required by local policy to come to scene or meet en route”. Change text to read “Assess baby; stable”. 9a approved.

CPG 9b – Approved.

CPG 9c – Change text in box to read “Contact GP/midwife/medical team as required by local policy to come to scene or meet en route” as for 9a. 9c approved.

CPG 10a – Approved.

CPG 11a – Approved.

CPG 12a – Change text in the “Note” text box to read “EMT’s may not compel a patient to accompany them or prevent a patient from leaving the ambulance vehicle at any time.” 12a approved.

CPG 12b – Change text in the “Note” text box to read “EMT’s may not compel a patient to accompany them or prevent a patient from leaving the ambulance vehicle at any time.” 12b approved.

CPG 13a – Approved.

Following a presentation from Vincent Cronly and Cyrus Mobed at the request of Dr. John Connaughton Consultant Physician, Portlaoise hospital, a draft CPG “Chronic Obstructive Pulmonary Disease -Decision tree” was tabled for discussion. It was agreed to consider a CPG specific for acute exacerbation of COPD but not aimed at patients with COPD who experience trauma or other medical conditions. The Chair asked the Director to draft a CPG for circulation and consideration by the Chair, and all the medical practitioner members of the MAG.

CPG 13b – Add ® to Entonox. 13b approved.

CPG 13c – It was agreed that the timings should be changed to read “repeat at 3-5 mins”. SBP of <90mmHg was clarified as a contraindication. The chair to reference the BNF to review possible interaction with other impotence medication. 13c approved.

CPG 13d – Approved.

CPG 13e – Approved.

CPG 14a – Move main text boxes to appendix and remove last sentence “all burns are time critical”. 14a approved.

CPG 15a – It was agreed to review this guideline in its entirety and keep only the clinical elements. The draft will be prepared for the Chair’s consideration and will be included in the next publication as an appendix. Subsequently all “Go to CPG 15a” text boxes throughout the manual will be deleted.

16a – Typos acknowledged. Should acknowledgement of source be required the Director will determine this when the MIMMS group are engaged. 16a approved.

CPG 16b – Approved.

CPG 16c – Change text to read “Cap Refill > 2 seconds or pulse > 120. 16 c approved.

CPG 16d – Approved.

CPG 17a – Typos acknowledged. 17a approved. The area of DNAR orders and the implications for pre – hospital may be examined in the future, as appropriate.

It was agreed that all “side effects/special precautions” boxes be removed from the medication guidelines as they now appear in the formulary.

Resolution: That the CPGs be recommended for approval for publication.

Moved: Michael Seaman

Seconded: Joe Foy

Carried without dissent

3.0 Medications Formulary for approval

Pauline Dempsey presented five completed pages from the medication formulary prepared in association with the School of Pharmacy RCSI, for approval.

- Aspirin
- Nitrous Oxide 50% and Oxygen 50% (Entonox®)
- Oxygen
- Glucose gel
- Glyceryl trinitrate; see 13c above.

Resolution: That the five formularies be approved.

Moved: Michael Seaman

Seconded: Joe Foy

Carried without dissent

4.0. CPG Manual – general layout and suggested items for appendices

Pauline Dempsey discussed the layout for the new CPG manual and invited the group to submit any suggestions as soon as possible. Any items received will be considered by the Chair for inclusion in the next publication. Brian Power tabled a paper “Continuum of care”. It was decided to allude to this in the CPG manual’s introduction.

5.0 AOB

5.1 Assessment Sheets

Brian Power tabled 8 assessment sheets for review prior to the next MAG meeting where recommendation will be sought.

- 1.1.2 Primary assessment – AED in cardiac arrest (Asystole-cease resuscitation)
- 1.2.2 Primary assessment – AED in cardiac arrest (Asystole-continue CPR)
- 1.4 Primary assessment – AED in Cardiac Arrest (PEA)
- 9.1 Secondary assessment - Completing a Patient Report Form
- 9.2 Secondary assessment – Patient history taking
- 10.1 Secondary assessment – Demonstrate control of epistaxis on a simulated patient.
- 19.1 Secondary assessment – Normal childbirth (pre delivery and delivery)
- 19.2 Secondary assessment – Normal childbirth (post delivery)

5.2 Brian Power distributed the Candidate Information “NQEMT – EMT” examination booklets.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair



Medical Advisory Group Meeting
Tuesday 22nd January, 2002 10.30 am
Meeting Report

Present:

John Burton
Vincent Cronly
Patrick Plunkett
Vincent O'Connor
Macartan Hughes
Declan Lonergan
Joseph Foy
Fergal Hickey
Lawrence Kenna
Mags Bourke
Sean Creamer
Mark Doyle

Apologies:

Conor Egleston
Gerard Bury
Stephen Cusack
Tony Ryan
Colm Murphy
Julie Woods
Fergus McCarron
Brian Abbott
Michael Seaman

In Attendance:

Geoff King
Brian Power
Pauline Dempsey
Sharon Gallagher

1. Minutes of MAG meeting 11th December **Accepted.**
2. **Agreed:** Ms Pauline Dempsey in consultation with Mr Mark Doyle to establish process / subgroup for SOP/AOP progress. **(PD)**
Mr Fergal Hickey to check with Mr Fergus McCarron on Limb Fracture SOP. **(FH)**
3. **National Examination July 2002:** Update by Mr Brian Power
 - 3.1 1st Workshop held January 15th – 17th. Group were nominated from Ambulance Services and Training Schools.
9 from services – 2 Training & Development Officers, 2 Operations Officers , and 5 EMTs.
1 **PHECC** representative – Mr Brian Power

- 1st Stage/Workshop – Writing questions
- 2nd Stage/Workshop – Review IHCD question bank
- 3rd Stage/Workshop- Commence writing PHECC question bank

PHECC will have intellectual copyright on any new question developed..

- Skills Workshop** – currently in progress (January 21st – 24th)
- 4 in group – looking at Skill stations instead of skill sheets
 - 6 critical skill stations – Use of AED
 - Airway Management
 - Cardiopulmonary Resuscitation
 - Haemorrhage Control
 - Patient Assessment
 - Primary Survey
- Each of the above will have sub-elements.

OSCE timeframe – 8 minutes per skill station
2 minute interval
This will permit 9 candidates to be assessed in 90 minutes.

Critical elements not looked at yet.

- 3.2 Criteria for EMT Examiners discussed as on material handout distributed
- 3.3 Venue for exams discussed: Due to equipment access exams are proposed to take place in Ambulance Training Schools.
PHECC to explore several venues (PHECC)
- 3.4 1st National Examination likely to be held in October 2002 as first cohort will not be available until then.
Accreditation Committee yet to approve process.
1st Exam likely to involve 30-40 students (NATS)
Exams will take 2 days, 18 candidates (approx) per half day
- 3.5 Cost element – proposed €50 – €60 fee – not finally decided - **Council to approve**
- 3.6 Accreditation process for EMTs trained outside of Ireland.
Comparing syllabus taught to these EMTs, to Irish syllabus, from this comparison, there will be three possible outcomes:
 - 1) Agree that syllabus is comparable and acceptable
 - 2) Agree that the syllabus is comparable and recommend they complete examinations
 - 3) Agree that syllabus is not comparable and need to do additional training before examination.The process of accreditation will take place through PHECC
- 3.7 Employers should note the two ways to accede to PHECC Register are either by examination or accreditation. When recruiting EMT who qualified outside Ireland, this process must be followed.

3.8 It was emphasized that CAOs should know implications of Accreditation with PHECC.

Geoff King to approach CAOs on process of EMTs who have been trained outside of Ireland joining Irish Ambulance services.

(GK)

4. Legislation

4.1 Legislation: handout distributed – 3 levels of emergency care – schedule of medications discussed.

4.2 Issue of Intra-hospital transfer of patients was discussed, the relevance of EMT training and intra-hospital treatments and interventions questioned – what is responsibility of PHECC in this area. – **PHECC to look at this area and return to MAG (may need to be flagged with Dept of Health)**

4.3 Issue of EMT professional accountability was raised, EMT's responsible for own actions in circumstance of instructions from any Registered Medical Practitioner on scene of emergency (EMTs not compelled but have ability to follow Doctor's instructions).

4.4 Discussion regarding the identification of Medical Practitioner – **Phecc to come back to MAG** on this area, needs to be flagged with Department of Health – EMTs must satisfy themselves on authenticity of Doctor and quality of advice. (PHECC)

4.5 **MAG Agreed** – that 1st Responder level should be included in “draft collaborative framework for administration of medications (**with further details**)

4.6 **Highlighted** that it is important to have level of training (which is less than EMT training) for certain defined circumstances. The need for specification of situations (i.e. environmental / remote) was emphasized.

4.7 **MAG agreed** with proposed PHECC “legislative framework for 3 levels of administration of medications” – Agenda item retained.

4.8 **PHECC to come back to MAG -** with further details of framework of legislation on medications (significant controls on medications – procedure for new drugs etc.). (PHECC)

5 EMT Database to NQEMT Register

5.1 Hand out on “draft process for individuals to accede from the database of successful completion of EMT Training to the NQEMT register” distributed to MAG members. Issues on handout discussed.

5.2 **Suggested by MAG** that it will be a generational change, to ensure only NQEMT's on ambulances;

- Suggested that at least 1 registered NQEMT on every ambulance by a specified year
- and gradual change to at least 2 registered EMTs on every ambulance by a second specified year

5.3 “Bridging Courses” highlighted – improve standards and improve confidence, but not feasible for gaining qualification

Example highlighted - North Eastern Health Board

5.4 **MAG agreed** on criteria for transfer to NQEMT register (as on handout) following a discussion detailing the situations where EMT’s don’t sign up for NQEMT.

Geoff King highlighted that wording on document will need development, (GK)

5.5 Highlighted that the Training Institutes need to provide evidence of training as well as the individual.

5.6 Commitment to continued education was emphasized

Section 2 , last item of handout amended as follows: “Individuals to sign statement confirming: Understand that there will be three yearly continuing education and competence assurance requirements to remain on the register”

Amended to “...understand that there will be **requirements** for continuing education and competence assurance to remain on the register”.

5.7 Benefits of NQEMT must be flagged/advertised to all staff. Process is ongoing in discussion with Council

5.8 Discussion ensued regarding payment of fees, issues questioned

- payment of fees by either the relevant Health Board or the individual
- will the fee be tax deductible

5.9 **Pauline Dempsey** to approach Revenue Commissioners to query issue of tax deductible (PD) payment of fee.

6. Building Capacity Project: Work in progress

6.1 Reference to handout from December MAG meeting. – The consultative process between PHECC and the Stakeholders in the ambulance service is underway . **P Dempsey** to report on current practice and data collection.

7. Development of Training Proposal: reference to handout from December meeting (GK)

Geoff King to come back with overview of Training Proposal.

8. MAG Membership: MAG informed that Council accepted amended MAG members list from December MAG meeting. **(GK)**

Registered Nurse,
Generic position

Geoff King to come back to MAG on this issue

9. AOB -

9.1 SOP for Psychiatric illness discussed – should an extra SOP on this area be included. Current developments in legislation in relation to enforced hospitalization for psychiatric patients was highlighted.

Action: Geoff King to explore opportunity for PHECC involvement in proposed new legislation. (GK)

9.2 MAG informed that Department of Health & Children acknowledged receipt of EMT-A material from PHECC.

Next MAG Meeting: Tuesday 19th February, 10.30 am. PHECC Office



Medical Advisory Group Meeting
Tuesday February 19th 2002 10.30 am
Meeting Report

Present:

John Burton
Michael Seaman
Sean Creamer
Macartan Hughes
Fergal Hickey
Joseph Foy
Vincent O'Connor
Mark Doyle
Lawrence Kenna
Stephen Cusack
Declan Lonergan

Apologies:

Julie Woods
Mags Bourke
Colm Murphy
Gerard Bury
Vincent Cronly
Cyrus Mobed
Kevin Flannery
Tony Ryan
Patrick Plunkett
Fergus McCarron
Brian Abbott

In Attendance:

Pauline Dempsey
Brian Power
Liz Dempsey
Sharon Gallagher

Issues arising from January MAG Meeting Report:

- 4.8** Pauline Dempsey outlined that the Director has been in contact with Dept of Health and Children in relation to legislation regarding administration of medications. The draft framework as discussed at the last MAG meeting is an appropriate method to progress the project.
- 9.1** The Mental Health Act 2001 was enacted in July 2001 and provides for the establishment of the Mental Health Commission. The Act was designed to be implemented on a phased basis and is expected to be fully operational within the next 3-5 years. Nominations to the Commission have been requested from appropriate bodies and the Minister of Health & Children is expected to make appointments to it shortly. A working group was established in October 2001 to review the practice of psychiatric patient escorts. The Ambulance Service is represented on the group by Mr. P. Grant CAO, NEHB.

- Michael Seaman informed MAG that there is also a sub-group in NEHB set up by P. Grant.

- The appropriateness of PHECC to be represented at Committee level on the Commission was raised.

PD

5.9 Project Officer PD approached revenue Commissioners. Receipt of query received and awaiting response regarding tax credit against payment of registration fees.

- Fergus McCarron contacted regarding SOP on limb fractures will bring to MAG on return to NWHB.

Meeting Report agreed.

1.1 Amended SOPs in print and current SOP reviews

Handouts distributed and discussed – Revision of SOP Manual
Printed Version 2 amended SOP 1A, 1B and 1C distributed and Training &

Development

Officers asked to collect and distribute to EMTs for insertion in manuals throughout each

board. Lawrence Kenna requested letter to be sent to Training and development Officers regarding version 2 of SOP 1A, B & C outlining amendments. **PD**

1.2 Paper 1 discussed how often review process of SOP Manual should take place.

Chair suggested that for immediate future the process of review is ongoing. After reissue of manual, following republication, process might be on a 4 yearly basis. Chair to liaise with Ms Pauline Dempsey to develop solid plan and return to MAG.

MD

& PD

Ms Pauline Dempsey brought to the attention of the MAG members that PDF file of amended Version 1 SOPs will be emailed to all MAG members in coming week.

Members instructed by Chair to review this SOP file for next MAG meeting.

Next MAG meeting will focus on critical analysis of SOP

MAG

1.3 SOPs Outstanding (missing from manual):

SOP 1D – Neonatal Resuscitation: To be agreed at next MAG

BA

SOP 8 - Limb Fracture – to be agreed

FmC

SOP 9 - Emergency Delivery

BA & DL

SOP 12 - Psychiatric illness – behavioural disorders

VO’C

SOP 14 - Ambulance Operational Procedures – MAG propose to approach CAOs and to agree on one SOP regarding Operational Procedures

MAG

1.4 SOPs for consideration for inclusion in new Manual

- Continuum of care – not agreed, to be circulated for approval

- Umbilical cord complications - could be included on side box on emergency delivery SOP

BA & DL

- Person under the influence of alcohol & drugs – covered under SOP of behavioural disorder **VO’C**
- Hypoglycaemic attack & Glucogel – to be looked at on SOP & AOP level in area of legislation and if covered by “altered level of consciousness” SOP. **VO’C & JB**
- Adult / Paediatric Burns – including Water gel **D Lonergan & PB,**

DB

NOTED: GENERIC NAME FOR WATERGEL TO BE USED ON SOP

- Major Emergency/Incident SOPs to be minuted in sub-committee meeting

1.5
EMTs.

It was raised that “ceasing resuscitation” in Pre-hospital environment is an issue for

addressed.

Above issue not covered on SOPs - **MAG agreed that above issue should be**

Declan Lonergan will draft an SOP on “ceasing resuscitation” for consideration. **DL Project Officer** advised of a public advertisement seeking submission for the “Coroners Rules” which may be relevant for SOP.

1.6

MAG agreed that obtaining a 12 lead ECG is at SOP level in cardiac management.

Example - “Consider 12 lead ECG if available”

PD to adapt the AOP draft to SOP for consideration.

PD

- Printing tender enquiries to be made by PHECC

PHECC

- Meeting of Clinical Care Committee to be arranged immediately after MAG meeting.

- PHECC to draw up summary sheet of all amendments to SOPs and to be sent with PDF files

PHECC

- A pharmacist will be co-opted on to MAG for their expertise with Drug formulary for both SOPs & AOPs.

PD

to follow up

2.1

AOP Current status

Chair suggested - need to get agreement on initial AOP that are drafted

- Need to identify evidence base for all AOPs

Outstanding AOPs	{	Adult Respiratory Distress	LK & MB
		Convulsions/Anaphylaxis	CM
To be agreed		Diabetes	JB
		Paediatric Respiratory Distress	TR & BA

2.2

MAG suggested Trauma Pain Management AOP to be removed and include pain control reference box on each AOP.

- 2.3 PHECC to circulate list of current draft of AOPs. **PHECC**
- 2.4 PHECC to confirm with members who are working on specific AOPs – to reactivate efforts.
PHECC
- 3.1 National Examination: Update – Mr. Brian Power – handouts (skill lists and sheets) distributed and discussed.
- 6 critical skills
- 19 non-critical
- 3.2 MAG suggested amending terminology of “critical” and “non-critical”. It was suggested to use the Terms Section 3 for “Critical” and Section 4 for “Non Critical”. Brian Power to come back to MAG with reviewed terminology.
BP
- 3.3 **MAG agreed on following policy on resits:**
- (a) If a candidate is unsuccessful in one skills station from section 3 of the NQEMT Examination he/she shall be offered a resit in that skills station.
 - (b) If a candidate is unsuccessful in three skills station from section 4 of the NQEMT Examination he/she shall be offered only one resit in each of the unsuccessful skills stations.
 - (c) No resits shall be offered if a candidate is unsuccessful in two or more skills stations from section 3 and or four or more skills stations from section 4 of the NQEMT Examination.
- 3.4 **MAG agreed on following policy on final resit:**
- (a) If a candidate is unsuccessful in the resit in section 3 of the NQEMT Examination and is successful in all other skills stations he/she shall be offered a final resit in the section 3 skills station.
 - (b) No other resits shall be offered.
- 3.5 **MAG agreed to forward “Draft Skill List” to NATS for use in training.**
- 3.6 **Ratification of “draft Skills list” by MAG.**
MAG agreed to review “draft skills list” as distributed at meeting. Should no amendments or queries be received by Brian Power (PHECC) within 48 hours of the MAG meeting, the skills list as submitted shall be deemed approved.
4. **Building Capacity Project:**
Pauline Dempsey distributed handout on Patient report forms. Ms Dempsey requested MAG members to review document for next MAG meeting.
- 4.1 **Minimum dataset (data entry) – Ms Pauline Dempsey agreed to research and produce draft paper on suggested minimum data set based on international practice.**
PD

5.

AOB

Chair suggested that updates from meeting agenda items could be emailed to members for information.

Next MAG Meeting **Tuesday 9th April 10.30 am to 3pm** in PHECC Office.
Agenda will focus on SOP reviews.



Medical Advisory Group Meeting
Tuesday April 9th 2002 9.30 am
Meeting Report

Present:

Michael Seaman
Declan Lonergan
Joseph Foy
Sean Creamer
Mags Bourke
Lawrence Kenna
Mark Doyle
Conor Egleston
Cyrus Mobed
Vincent O'Connor
Patrick K. Plunkett

Apologies:

Fergal Hickey
Noel Flynn
Colm Murphy
Stephen Cusack
Brian McNeill
David McManus
Julie Woods
Brian Abbott

In Attendance:

Geoff King
Brian Power
Pauline Dempsey
Sharon Gallagher
Liz Dempsey

Issues arising from February MAG Meeting Report:

- 1.6** - Pauline Dempsey advised that a specification document is being drafted to tender for republication of the SOP manual. Ms Dempsey requested information / assistance from MAG on tender. Declan Lonergan volunteered to assist Ms Dempsey. **PD & DL**
- It was brought to the attention of MAG that if SOPs were to be reissued as pocket sized handbooks, difficulties may arise with legibility etc. Pauline Dempsey and Declan Lonergan agreed to look at this issue. **PD & DL**
- Pauline Dempsey advised that a Pharmacist is available in the National Medicines Information Centre (NMIC) to assist and advise MAG to produce an appropriate drug formulary for the SOP manual. Acknowledgement and thanks to Mr P. Plunkett for initiating the contact.
- MAG agreed to continue with the existing "drug SOPs" as well as considering a drug formulary.

- **Term of SOP – Standard Operating Procedure**

It was outlined by Director Dr Geoff King that Council seeks MAG's direction on any terminology currently in use in SOPs, Pre hospital emergency care and major emergencies, and specifically the semantics of the term – "Standard Operating Procedure". The Council's functions in the Statutory Instrument, that includes the wording "SOP or protocols", needs to be amended for other reasons. Hence if it were thought there is a better term than SOPs, now is the time to decide so. MAG members asked to consider this for deliberation at next meeting. Members suggested that the title should reflect their clinical nature. **All MAG**

4. Building Capacity Project Update

PHECC received Partnership Funding of €25,000. This funding will be used to second Mr Sean Creamer on to the PHECC Project Team to engage on a broad based consultative process.

Training & Development Officers, Declan Lonergan & Lawrence Kenna will also assist in developing the nationally agreed minimum dataset with definitions. It was outlined by Geoff King that the work on developing PRF will continue under the auspices of MAG. Ms Pauline Dempsey and Mr Sean Creamer will be key contacts in project.

- Added to the project is an exploration into the use of pre-hospital terminology nationally. It was suggested by Pauline Dempsey that a glossary of agreed terms could be useful.
- Mr Conor Egleston highlighted problems arisen in past in NEHB in relation to terminology difficulties with "Medical Emergency" and "Major Emergency".

February MAG Meeting Report agreed

Meeting Report of Major Incident / Emergency SOPs from sub-committee meeting of MAG on Tuesday 19th February.

- Ms Pauline Dempsey outlined the issues discussed in sub committee meeting on MIMMS. Confusion with terminology crossborder and with the Fire services & Garda is evident.
- It was suggested by Mr Conor Egleston and agreed by MAG that we should make contact with MIMMS Course provider in UK and request how many EU countries have formally adopted their programme. **PD**

Meeting Report of sub-committee meeting regarding Major Emergency/Incident SOPs agreed.

1.1 Revised SOPs and Current SOP recommendations

Ms Pauline Dempsey discussed framework to manage the SOP developments in the future. Please find attached Paper -“Framework to manage revision of and additions to SOP manual” - for your attention, as agreed by Chair, Mr Mark Doyle.

MAG will remain the expert group on SOPs and best practice guidelines.

1.2 Table of SOP recommendations (28th March) distributed as reference for discussion.

Agreed amendments for all SOPs :

- 1) A & E Department - to change to Emergency Department (ED)
- 2) “Transport & Treat” to replace “Transport” cross-boxes for all SOPs
- 3) In assess airway boxes change “open” to “airway patent?”

SOP 1A - In text reference box on Chest compressions, remove text in brackets “(5:1 ratio when patient intubated)”.

SOP 3A - In Notes Box change “arrest” to “arrival” of AED.
In “shock 1, 2 & 3” text boxes remove joule levels from boxes.

SOP 4B & 5B - Change Age of Child from “0 – 12 years” to “ Infant / Child 0 – 8 years”

SOP 6A - In Multisystem trauma box Check PHTLS miles per hour. PD

SOP 7A -In indications for spinal immobilisation box add following text below box: “This list is not definitive or exclusive”

- In box “return head to neutral position if” change text to “return head to neutral position unless on movement:
 - Increase in pain
 - Increase in resistance
 - Increase in neurological symptoms”

SOP 5A, B & 7C - In both text boxes “Check C.S.M.” . – change to “Check C.S.M. in extremities”. Remove text “distal pulses”.

SOP 7C - In second “Check C.S.M.” text box change text “check” to “recheck”.
- Remove task analysis detail in “Application of extrication device - box” replace with sentence - “Apply extrication device”

SOP 10A - Box from “if chest pain thought to be cardiac” – yes - change text in box to “Give aspirin, consider GTN, Entonox”

SOP 11A- Change box “Go to SOP Hypoglycaemic attack” to “Go to SOP Hypoglycaemia” – remove “attack”.

SOP 13A – In circle “history of COAD” change to “history of COPD”

SOP 13B - In Contraindications box include text “intestinal obstruction”

SOP 13C – GTN proposal from Declan Lonergan discussed.

Under “administer GTN” circle remove “no if” and replace with “do not give if”

SOP 13D - Aspirin proposal from Declan Lonergan discussed.

- Under “Administer Aspirin” circle remove “no if” and replace with “do not give if - allergic to aspirin

- active GI Ulcer

- bleeding disorder”

- Remove pregnancy from contraindications list

PD

- “Dosage of Aspirin” change to 300mg

SOP 15A –Remove text boxes “Scene safety, survey, situation” and “strap yourself in” and replace with text “consider safety issues”

MAG agreed the above amendments concluding review into existing SOPs.

1.3 New SOPs adjourned until next MAG meeting.

Ms Pauline Dempsey will circulate New SOP drafts for consideration by MAG with a deadline for comments / recommendations prior to the next meeting. **PD**

2. National Examination: Skill sheets

MAG suggested to change the critical element from “dose” to “contraindications”

MAG formally ratified 25 skills sheets, *Proposed by Michael Seaman*

Secoded by Joe Foy

Skill lists to be included in next MAG agenda.

3. National Examination: Section 2 short answer, number of questions & correction procedure.

Handout of “Draft Outline process for correction of short answers” distributed to MAG for discussion. At this early stage it was generally agreed that Process A was fairest method of marking/correcting.

It was also noted by MAG that 1 mark (5%) of difference between examiners was too tight and 2 marks (10%) was seen as more acceptable.

PHECC to come back to MAG on assessment of short answers.

PHECC

4. Assessment for non-nationally trained EMTs

NATS proposal document – “Practical Assessments for foreign trained EMTs” distributed.

MAG suggested to use existing examination processes, i.e. Test items and skill sheets and not develop other processes. When other training Institutions are accredited they are to be offered opportunity to quote for an assessment process. Brian Power to come back to MAG when competency assessment is formalised with NATS. **BP**

5. AOB

ISIC Conference: Details of ISIC conference circulated for information.

Date for next MAG meeting to be decided and notification to be forwarded to members.



**Medical Advisory Group Meeting
Wednesday 29th May 2002 10.30 am
Meeting Report**

Present:

Joseph Foy
Vincent O'Connor
Lawrence Kenna
Mark Doyle
Sean Creamer
Macartan Hughes
Declan Lonergan

Apologies:

Julie Woods
Michael Seaman
Fergal Hickey
Brian Abbott
Vincent Cronly
Mags Bourke
Cyrus Mobed
Fergus McCarron
Connor Egleston
Tony Ryan
Geoff King

In Attendance:

Pauline Dempsey
Brian Power
Liz Dempsey
Sharon Gallagher

Matters arising from 9th April MAG Meeting Report:

Framework to manage revision of and additions to SOP manual

MAG agreed on above document as a framework to manage future revisions and additions to SOP manual.

Correction of Meeting report 9th April

SOP 15a: It was agreed by Chair to amend Meeting Report of 9th April, to delete sentence in 1.2 "Noted that this area needs to be readdressed by the Training and Development officers". The issues of insurance and EMTs wearing safety belts needs to be examined again. **Meeting Report from April MAG agreed.**

1. SOP New additions

SOP 8a Limb Fractures - SOP 8a agreed

SOP 10b- 12 Lead ECG

Page layout – reverse order (right column to left)

Change text box "patient stable" – to CUPS decision?

Delete text "yes" from arrow and replace with "UPS"

Delete text "no" from arrow down and replace with "C"

Text box "do not acquire 12 lead ECG..." delete "do not" and add if possible to end of sentence"

SOP 10b agreed with amendments

SOP 13e – Glucose Gel

Change text box “dose: 10 – 20g”, delete “– 20g”.

Change text “repeated in 10-15 minutes” to “repeat as required”

In route text amend to read Route: “Sublingually / buccal”

For further review.

Data sheet required for this SOP in consultation with Mags Bourke in relation to the following: temperature, volume, adverse chemical affect if aspirated, maximum allowable dose.

MH

SOP 12a Behavioural Emergency – *for further review* VO’C

SOP 14a Burns Management

Column 1 (thermal, mechanical and radiation burns) - Change “thermal heat” to “thermal source”

Column 2 (chemical burns) - Change “follow instructions from..” to “communicate with...”.

Add sentence “brush off all chemical dust” before sentence “apply continuous irrigation...”

Add in brackets “(TREM Card)” to “get details of chemical if available”.

Column 3 – Remove **bold** font of “monitor cardiac rhythm”

Delete sentence “consider spinal immobilisation 7a” from column 3

Text box – “Ventilate with 100% O₂” – delete words “ventilate with” and replace **with** administer O₂

SOP 14a agreed with amendments

SOP 16a Major Emergency (Major Incident) – The First Ambulance Crew

In text box following below “EMT medic (attendant)” add “M” to acronym “ETHANE” box “M – Major Incident”

In sentence “A- Access routes to scene” – amend to include “Access / egress routes to scene”

SOP 16a agreed with amendments

SOP 16b Major Emergency (Major Incident) – Operation Control

Spelling error Text box “inner cordo” should read “inner cordon”

In 2nd half of SOP in text box “controlled entry to Bronze area.....” reverse order of “Subject to authorisation by Garda or Fire officer” to read “subject to authorisation by Fire Officer or Garda”

SOP 16b agreed with amendments

SOP 16c Major Emergency (Major Incident) – Triage Sieve

Remove text box “Start” and replace with text box “Commence process”

In text box “is casualty walking” amend to read, “Can casualty walk?”

In “open airway” text box add text “1 attempt”

Add information box at bottom of SOP including text “START Simple Triage and Rapid Treatment”

SOP 16c agreed with amendments

SOP 16d Major Emergency (Major Incident) – Triage Sort

In first sentence of SOP “N.B. The triage sort...” amend sentence to read “ The triage sort is carried out at the Casualty Clearing Station and beyond”

SOP 16d agreed with amendments

SOP 17 – Continuum of Care

Following discussion by MAG it was suggested by Chair that “Continuum of Care” would not be published in SOP format, but could be developed as a principle of care. It was decided that it would sit better in the introductory passages at the beginning of the manual.

To be reviewed.

Continuum of care details to be circulated to MAG members by email **BP**

SOP 1d – Neonatal Resuscitation

2 versions of SOP: 1) Brian Abbott

2) P. Dempsey

MAG agreed with the information and critical contact in BA version, design format needs to be addressed.

SOP 1d agreed with amendments

SOP 18a stopping and starting CPR – still work in progress GK

2.1 SOP Review

SOP 13b – Entonox

New contraindications suggested by M Bourke, Work in progress - **MH**

SOP 5a & 5b Secondary Surveys

The issue of estimating skin temperature and measuring core temperature was discussed. MAG agreed to remove “skin” from text box “repeat vital signs” to read “repeat vital signs, pulse, respirations, BP, level of consciousness, temperature, GCS”.

SOP 5a & b agreed

2.2 – Name Change: SOP term

Further to previous MAG meeting a revised term to “Standard Operating Procedure” was discussed and the following terms were decided upon:

- Clinical Practice Guidelines (CPGs) to replace SOPs
- Clinical Practice Manual (CPM) to replace SOP Manual

It was agreed that there are nuances with the name change from operating procedures to clinical guidelines.

Guidelines are statements, which will assist in decision making for specific clinical conditions. They act as a quick reference to the EMT by helping to think through some of the clinical issues. Their advantage over SOPs is that they empower the EMT to exercise professional judgement as an accountable health care practitioner and will have a positive effect on the way EMTs practice and will support their professional profile.

Pocket option was discussed for CPGs

New terms were agreed.

2.3 References

Agreed that references were needed for each SOP
PHECC to email reminder to MAG members

PHECC

2.4 Appendices

Additional appendices were suggested as an opportunity to develop the new CPM to include more clinical information. Examples included: CUPS, Paediatric values, abbreviations, definitions, etc. To be developed further - **MAG**

2.5 UK JRCALC advice to use vacuum mattress SOP 7a

Upon discussion it was agreed to insert information box on SOP 7a with the following text: “if time of transport exceeds 30 minutes consider vacuum mattress in addition to spinal board”

3. Review of Skills List

A question was posed in relation to the appropriateness of examining every skill on the Skill list for the NQEMT examination. It was suggested that skills should be divided into three areas, must know, should know and nice to know. The chair suggested that a small working group consisting of Brian Power, Project Officer and a representative of the Training Institutions that currently have candidates for the NQEMT examinations be set up and report back to MAG.

BP & MH

4. Assessment of Non-National EMT – (Phase 3 of the Accreditation process)

Brian Power, Project Officer spoke on this. Following the criteria laid down at the previous MAG meeting he proposed the following;

Theory: The applicant for phase 3 should be assessed on the SOP’s that reflect Irish EMS practice. The SOP’s identified were; 3a, 4a, 4b, 6a, 7a, 10a, 13a, 13b, 13c, 13d and 15a. Also the CUPS categories.

Skills: The skills identified were AED in cardiac arrest (Skills Sheet 1), trauma assessment (Skills Sheet 5.1) and medical assessment (Skills Sheet 5.2).

The process for assessment as outlined was accepted by all present

5.1 AOB

It was suggested by Chair that a Vice-Chair be elected to the M.A.G.

Mr Sean Creamer nominated Dr Mags Bourke; it was however outlined that the election process according to Councils Standing Orders would first need to be examined.

5.2 Correction of short answers for NQEMT.

Brian Power, Project Officer, presented the final draft of the process for correction for

short answers for the NQEMT examinations. This process was proposed by Mark

Doyle and seconded by Vincent O’Connor and was passed without dissent.

5.3 It was outlined that PHECC are contributing an article in the upcoming issue of the Ambulance and Emergency Services Ireland magazines.

Signed _____ Date: _____

Mr Mark Doyle / Dr Mags Bourke
Chair / Vice Chair of the Medical Advisory Group



Medical Advisory Group Meeting
Tuesday 17th September 2002 10.00 am
Meeting Report

Present:

Mags Bourke – Vice Chair
Gerard Bury
Sean Creamer
Conor Egleston
Joseph Foy
Macartan Hughes
Lawrence Kenna
Declan Lonergan
Fergus McCarron
Peter O'Connor
Vincent O'Connor
Patrick Plunkett
Michael Seaman

Apologies:

Brian Abbott
John Burton
Vincent Cronly
Stephen Cusack
Mark Doyle
Noel Flynn
Fergal Hickey
Cyrus Mobed
Paul Robinson
Tony Ryan

In Attendance:

Liz Dempsey
Sharon Gallagher
Geoff King
Brian Power

Dr Mags Bourke, Vice Chair in the absence of Mr Mark Doyle, chaired the MAG meeting

1. Presentation by Dr Mags Bourke on HEMS

- a. Draft document regarding submission of guiding principles from Council to HEMS feasibility group distributed to MAG.

Recommendation: - To amend “Southern Ireland” to “Republic of Ireland”.
- To link items 4 & 6 together.

Proposed by: Patrick Plunkett

Seconded by: Sean Creamer

Agreed without dissent

2. Meeting Report:

Item 1 SOP 16c - It was agreed by Chair to amend Meeting Report of 29th May, and subsequently to amend the actual SOP 16c as follows: Remove the word “start” from first text box on SOP 16c and delete text box at bottom of page with “Start abbreviation - explanations”.

Recommendation: That the amended Meeting Report from May 29th be agreed

Proposed by: Mags Bourke

Seconded by: Sean Creamer

Agreed without dissent

3. Draft Council National Examination Policy document for NQEMT (EMT)

- A document was distributed to MAG regarding the temporary composition of the Quality Subcommittee. Consisting only of trained examiners; 2 EMTs and 1 medical practitioner or 1 nurse.

For the October 2002 Examination it will be suggested to the Accreditation Committee that the Quality Subcommittee will comprise of Dr Geoff King, Ms Pauline Dempsey, Mr Sean Creamer and Mr Brian Power.

- *It was agreed that the Quality Subcommittee will report to MAG with feedback on the October NQEMT Exam.*

4. Examination Process: The revised NQEMT examination process document was distributed to MAG.

Resolution: Revised Examination Process be approved.

Proposed by: Mags Bourke

Seconded by: Joe Foy

Agreed without dissent.

5. Skill Sheets: Various suggested amendments were discussed including remaining critical elements from the secondary skills stations.

Resolution: Skill sheets be approved by MAG subject to amendments being incorporated by the Quality Subcommittee.

Proposed by Patrick Plunkett

Seconded by Gerry Bury

Agreed without dissent.

6. Skills List:

A document was distributed with recommended changes highlighted by Clinical Care and Accreditation Committees 27/06/02.

- Page 2 item 8 “selected” amended to “select”.
- Page 2 item b delete word “only”
- Page 2 Amalgamate item 7 & 8 and reword.
- Page 2 Final resit. It was agreed to “– Delete all reference to final resits”
- Page 5 Item 7.9. Remove “salbutamol”.
- Page 6 Notes on 8.5. The following text to be added “As rescue is not the direct responsibility of EMTs, 8.5 shall not be assessed under examination conditions”.
- Page 6 Note Item 9 Notes – It was agreed not to alter text for “9.6 & 9.7. It was agreed that 9.6 & 9.7 will not be assessed for October Examinations and that Training Institutions should incorporate Communications Module as per the 1995 Standards in their training.
- Page 6 10.1 – It was agreed not to alter 10.1.
- Page 7 11.3 – It was agreed that ETHANE be changed to METHANE in accordance with the MIMMS (2002, 2nd Edition) standard.
- Page 9 16 Notes – It was agreed as per document - “As the paraguard stretcher shall be supplied and operated under the control of a rescue agency it shall not be assessed under examination conditions. One of 16.2 or 16.3 shall be selected randomly.”

Resolution: The above amendments to skills list be approved.

Proposed by: Michael Seaman

Seconded by: Declan Lonergan

Carried without dissent

7.0 – SOP Name Change

Further to previous MAG meeting the revised term “Standard Operating Procedure” was agreed as “Clinical Practice Guideline”.

7.1 - Final Review:

SOP 1a – Below “assess responsiveness” circle (if patient is unresponsive) it was agreed to insert text “Turn on monitor”.

SOP 6a – Change the classification of adult and paediatric burns as recommended by Mr Paddy Bourke (ISBI). It was agreed to amend Adult burns to “any burns >10 % or any burns to FHFFP or circumferential”

It was also agreed to amend Paediatric burns to “any burns > 5 % or any burns to FHFFP or circumferential”

The need to revisit definition of Paediatric in age terms was outlined. It was agreed by Director that PHECC would flag term use in all SOPs and bring back to MAG.

CUPS Categories - As per changes for SOP 6a.

SOP 10a – In text box under “if Chest pain thought to be cardiac?” amend box underneath to read “Obtain a 12 Lead ECG, see SOP 10b”, delete “and transmit a” and “if available”. It was also agreed to delete text box “give aspirin, consider GTN, Entonox” and replace with text box “Go to SOP 10b”.

SOP 10b - In text box “Acquire 12 lead ECG” Delete following text “ patient is stable and:” and replace with CUPS decision.

Amend last sentence in same text box to read “**Consider** an ECG only if distance to medical facility is greater than 5 minutes”.

In text box on left “Acquire 12 lead ECG” Amend end of sentence, delete “if possible” and replace with “if obtainable”.

SOP 13b – Entonox - agreed

Recommendation: The above amendments be agreed

Proposed by: Michael Seaman

Seconded by: Declan Lonergan

7.2 New SOPs

SOP 9a – It was agreed that title to be changed to “Pre-hospital emergency child birth”

In text box “consider asking for midwife/medical team” It was agreed to amend to “ Seek midwife/medical team to come to scene or meet enroute”

It was agreed to return to SOP 9a to MAG at next meeting.

SOP 9b – it was agreed that title to be changed to “Pre-hospital emergency childbirth – umbilical cord complications”.

It was agreed to insert extra text box at top of SOPs after “Consider pre-arrival information” text box to read “Seek medical expert advice”

In bottom text box “transport without delay.....” Amend box, to read only “transport without delay” delete all other text in this box.

In text box on left of SOP reading “administer 100% Oxygen.....” Delete text “position mother appropriately with buttocks raised” and replace with text From SOP 9c “If partial delivery occurs en-route and delivery of the head is delayed , Ask mother to adopt knees to chest (McRoberts) position”.

It was decided to return SOP 9b to MAG at next meeting.

SOP 9c - it was agreed that title to be changed to Pre-hospital emergency childbirth – breech birth”.

It was agreed to move text box “seek expert help to come to scene or meet enroute” to centre of SOP i.e. directly underneath “breech birth – transport decision” text box.

It was decided to return SOP 9c to MAG at next meeting.

SOP 13e – it was agreed to return to SOP 13e at next MAG meeting – contraindications for discussion.

SOP 18a – it was agreed to delete the following text from “cardio pulmonary arrest” text box: “widely fixed and dilated pupils”.

It was agreed to replace “reversible rhythm”? text box with “Asystole”?

It was agreed that PHECC thoroughly review SOP 18a and return to next MAG meeting.

8. PHECC Process for Recognition of qualifications in emergency medical technology obtained outside the State: This revised document was distributed to MAG for approval

Resolution: The above revised process be approved

Proposed by: Joe Foy

Seconded by: Michael Seaman

Agreed without dissent

9. AOPs: It was suggested by the Director in consultation with Chair that a small group of MAG meet to discuss and finalise all AOPs and return to MAG for ratification.

It was agreed that a small group from MAG meet to finalise AOPs for ratification at next MAG meeting.

10. Building Capacity Project: Update

Director updated MAG on the PHECC visits to the Ambulance stations and control centres

in the health boards and Dublin Fire Brigade, updated maps outlining all the visits to date

were distributed to MAG.

11. AOB

11.0 – EMT-A Seminar – Prof Bury informed MAG of Seminar on EMT-A on November 5th 2002.

11.1 - Presentation by Mr Joe Kelly on PDAs (Personal Data Assistants) for NQEMT Examiners.

Signed _____ Date: _____

Mr Mark Doyle / Dr Mags Bourke
Chair / Vice Chair of the Medical Advisory Group



Meeting Report of the PHECC Medical Advisory Group held at the PHECC office

Naas on Tuesday December 6th 2002 at 9.30 am

Present:

Mags Bourke
John Burton
Mark Doyle
Joe Foy
Lawrence Kenna
Declan Lonergan
Peter O'Connor
Vincent O'Connor
Michael Seaman
Sean Creamer

Apologies:

Brian Abbott
Vincent Cronly
Stephen Cusack
Fergal Hickey
Macartan Hughes
Fergus McCarron
David McManus
Brian McNeill
Martin O'Reilly
Paul Robinson
Tony Ryan

In attendance:

Pauline Dempsey
Sharon Gallagher
Brian Power
Barry O'Sullivan

Acting Director's Update:

- The development of the selection criteria for the first two cohorts of EMT-A trainees is underway with all stakeholders.
- Dr Geoff King has been appointed as Medical Director to Council.
- ICT education initiative – PHECC has made funding available for a PC for each station. The Health Boards and DFB are looking at the viability of connecting to the Internet.
- PHECC ID cards – their potential is being explored.
- Research:

A research assistant, in the Department of Epidemiology and Public Health, RCSI, is preparing an evidence base for CPGs and CPG-As.

PHECC are in discussion with UCD to fund research in the area of control & dispatch.

1.0 Chair's Business: In accordance with Council's Standing Orders, MAG members were reminded of the requirement for confidentiality in particular where drafts are being developed.

1.1 MAG Meeting Report September 17th 2002:

Report agreed.

2. CPGs – Ongoing review: Draft documents distributed to members.

CPG 1a– It was agreed to include the following text boxes “Switch on AED” and “Apply defibrillation pads”.

CPG 1b & c – it was agreed to include the following text boxes “Switch on AED” and “apply monitoring leads”.

CPG 1a,b & c approved

CPG 1d – it was agreed that further attention to layout was required.
This item was held over for approval at next meeting.

CPG 10a & 10b – It was agreed to amalgamate both CPGs into 10a. It was agreed to change “Consider an ECG only if travel time to medical facility is greater than 5mins” to “10 mins.”

CPG 10a approved

CPG 13a – Under “P” on “CUPS Scale” layout amended to read “non-rebreather mask @ 15 Lpm...”- tolerates mask? – No, Nasal Cannulae@ 6 LPM...”Information box added “For COPD patients in particular monitor respiratory rate closely” Text box “ Refer to MSDS...” removed and subsequently from 13b.

CPG 13a approved

CPG 13e – It was agreed that the Pharmacist in RCSI should give direction on the outstanding issues:

- The contraindications of glucose gel
- The pH of the carrier gel
- Whether it is a licensed drug or food stuff
- Has it a product licence for unconscious patient.

This item held over for approval at next meeting.

3. CPGs new: Draft documents distributed to members.

CPGs 9a,b & c – Drafts prepared by B. Abbott thus far acknowledged, however, it was decided to seek advice from an Obstetrician to complete the guidelines. Dr Peter O’Connor agreed to make contact with a colleague Obstetrician in Rotunda for advice.

CPG 12a, 18a - Drafts prepared by Medical Director distributed to members.

CPG proposed for Hypothermia – Dr Peter O’Connor agreed to prepare a draft for next MAG meeting.

Item 3 held over for discussion at next meeting.

4. Building Capacity Project:

- Interim report on consultations, draft data set and definitions, and PHECC “glossary of terms” documents distributed.
- Map of consultation visits throughout the country to date were displayed for information.
The draft dataset with definitions and the glossary of terms held over for discussion at next meeting.

5. NQEMT Exam 2002

Exam report to council was distributed for information.

6.0 CPG-A’s: Draft Version 3 distributed to members.

CPG –A 1 Airway Management “Surgical airway” text box removed and replaced by “Go to CPG-A 2”.

CPG-A 2 Persistent foreign body airway obstruction: “Surgical airway” text box to be removed and replaced by “attempt intubation”.

CPG-A 3 Inadequate respiration: After “ Consider Naloxone” - “dose of 400 mcg and repeat if indicated” added.

CPG-A 4 Anaphylaxis: After “500 mcg Adrenaline IM” - “repeat x 1 if indicated” added.

CPG-A 5 VF & PVT: no changes.

CPG –A 6 PEA: no changes.

CPG- A 7 Asystole: no changes.

CPG-A 8 Seizure disorder/convulsions: no changes.

Following a discussion regarding the administration of diazepam it was concluded that the rectal route is a medically approved standard. However, safety issues for EMTs & patients need to be managed during training.

CPG- 9 Glycaemic Emergencies: no changes.

CPG-A 10 Hypovolaemic Shock:

- In light of emerging evidence from EMJ November 2002, it was agreed to task the RCSI evidence base research assistant with undertaking an in depth literature review on fluid administration pre-hospital care for adults and children.
- Dr Peter O’Connor will review a paper, which advocates the combined use of steroids and antibiotics to assess its implications for pre-hospital care.

CPG-A 11 Cardiac Chest Pain: no changes.

CPG-A 12 Paediatric Asystole/PEA – In “Consider causes” information box, after tension pneumothorax “See CPG-A 22” added.

CPG-A 13 Paediatric VF and PVT – Shock delivery was revised to read “2-4 joules kg” throughout the algorithm.

CPG-A 14 Paediatric Hypoglycaemia – 1st text box removed “13e”.

CPG-A 15 Paediatric Hypovolemia – Include “tachycardia” in “Features of” ...text box. As with the Adult Hypovolaemic shock guideline, the RCSI review will assist in further development of this guideline.

CPG-A 16 Paediatric Anaphylaxis – After “adrenaline IM” text box “Repeat x 1 if indicated” added.

CPG-A 17 Paediatric Bradycardia – The use of atropine was discussed with reference to AHA guidelines. P Dempsey to seek clarification with M. Bourke.

CPG-A 18 Paediatric Respiratory Distress – The need for a guideline to advise the management of a tension pneumothorax in Paediatrics was highlighted. Mr P. Plunkett at a previous meeting agreed to review the value of nebulised adrenaline or steroids.

CPG-A 19 Paediatric Seizure Disorders/Convulsions – Layout was changed to eliminate IV/IO access on patients post seizure. After “if pyrexial, cool child”- “Consider Paracetamol 125-250 mg rectally” was added.

6.1 CPG-As to be drafted for next MAG:

Adult: Bradycardia – Declan Lonergan

Pain management – Peter O’Connor

Ventricular Tachycardia with pulse – Declan Lonergan

Peri-arrest arrhythmias – Declan Lonergan

Paediatrics: Pain Management – Peter O’Connor

Tension Pneumothorax – P. Dempsey

It was agreed that MAG would review CPG-As draft Version 4 at the next meeting.

6.2 Medication Formulary: A document was distributed proposing the authorisation of medications administration to specific levels on NQEMT Register.

- P. Dempsey outlined that after meeting with Prof. John Kelly and his team from the School of Pharmacy, RCSI that they have agreed to assist in the development of a medication formulary and to advice on the administration of medications on all the CPGs.
- MAG recommended that Paracetamol and Lignocaine be included on the formulary

The concept of the draft of both the medication formulary and authorisation of medications administration was agreed by MAG.

7. AOB

- A schematic diagram of EMT training was distributed for discussion, it was decided to return the document to MAG at next meeting.
- EMT-A Test item writing group for EMT-A workshop is provisionally booked for 14/15/16th of January 2003. Call for Medical representation from MAG. Mark Doyle will discuss same with all the Medical Advisors and seek a nomination from the group to attend the 3-day workshop.

Signed:

Date:

Mr Mark Doyle
Chair MAG



Medical Advisory Group Meeting
3rd October 2001. 2.30pm
Meeting Report

Present:

Mark Doyle (Chair)
Mags Bourke
Patrick K. Plunkett
Kevin Flannery
Joe Foy
Macartan Hughes
Lawrence Kenna
Colm Murphy
Vincent O'Connor
Sean Creamer

In attendance:

Brian Power
Geoff King
Sharon Gallagher
Barry Bushfield, E & C Care Services, Victoria, Australia.
Martin O'Reilly (NEU)

Apologies:

Gerard Bury
Stephen Cusack
Conor Egleston
Noel Flynn
Fergal Hickey
Peter O'Connor
Tony Ryan
John Burton
Brian Abbott
Vincent Cronly
Julie Woods
Declan Lonergan
Fergus McCarron
Michael Seaman

Advanced/Standard Operating Procedures
Current status

Points agreed:

1) Agreed Process of Drugs Dosage in Advanced Operating Procedures:

- It was agreed that all drugs should be denoted in standard dosage format
- It was suggested that this standard be in weight, this to be agreed following pharmacist's input.

2) Advanced Operating Procedures: Adult Anaphylaxis A.O.P. was agreed as draft.
To be updated/amended for next MAG meeting

3A) (**Priority**) Standard Operating Procedures 1A, 1B & 1C to be amended and distributed via e-mail to all members of M.A.G. due to American Heart Association and ILCOR guideline updates. Members to send feedback on amended SOPs to Sharon Gallagher, Programme Development Support Officer, P.H.E.C.C. **within one week** of sent date via e-mail, in preparation for following MAG meeting.

3B) **(For Process)** SOPs for Major Emergency & Adult Convulsions will also be distributed as above, 2 weeks following current meeting, and to be returned to same in preparation for next MAG meeting. Sharon Gallagher to collate feedback, and prepare for next MAG meeting.

4) Draft SOPs/AOPs to be formatted with lines and arrows for convenience prior to ratification.

5) Information Technology issue on SOPs Training/Developments Packs CDs:
Vincent O'Connor recommended that SOPs for EMT training be used in PDF file Format.

Communication Issues:

All communication within MAG regarding AOPs/SOPs or any issues regarding group to be communicated through Sharon Gallagher, Programme Development, Support Officer P.H.E.C.C. e-mail sharon.gallagher@phecc.ie Direct Phone Number (045) 882082, Fax (045) 882089.

NEXT MAG Meeting:

Tuesday 13th November 10.30 am. P.H.E.C.C. Office, Naas.



Medical Advisory Group Meeting
13th November 2001 10.30am
Meeting Report

Present:

Fergal Hickey
Brian Abbott
Lawrence Kenna
Mark Doyle
Joseph Foy
Colm Murphy
Vincent O'Connor
Macartan Hughes
Declan Lonergan

Apologies:

Gerard Bury
Fergus McCarron
Tony Ryan
Peter O'Connor
Stephen Cusack
Julie Woods
Sean Creamer
Vincent Cronly
Michael Seaman
Kevin Flannery
Mags Bourke
Patrick Plunkett
Conor Egleston
Noel Flynn
John Burton

In Attendance:

Sharon Gallagher
Liz Dempsey

1. Minutes of previous MAG meeting: Martin O'Reilly to be included under "In Attendance" list. Minutes accepted.
2. Formal Greeting to be sent from MAG Members to Fergus McCarron, NWHB.
3. Target Date for full implementation of SOPs set for June 2002 – Letter to be sent to all Chief Ambulance Officers, **recommended** by M.A.G. to PHECC - regarding target date of June 2002 for SOP implementation for all EMT Training (to be agreed).
4. Need to come to definitive approach to SOPs –
 - Updating SOPs
 - Addressing recommendations / changes to SOPs
 - Adding new SOPsNeed Forum to deal with these issues -
 - Meetings on SOPs – do we set up a subgroup for SOPs only
 - Do we assign a certain number of MAG meetings a year for SOPs (i.e. quarterly)*Suggested that have stamped version of SOPs until further notice*
Also suggested that MAG meeting in January to be totally SOP oriented.

5. Format of Header of updated SOPs **to be decided**, i.e. version, publication date, replacing Previous named version etc. (may use format – SOP1A/V2/Nov01/MAG/PHECC). May need to be included on Preface Page.
6. Process needs to be set up as to identify who would be responsible for distributing updates to EMTs (Training & Development Officers)
7. SOP1A – The following amendments were decided upon:
 - “Breathing” text box “*absent or inadequate*” removed (not necessary).
 - Text box –“If none or inadequate...” removed and replaced with text over arrow “*No or inadequate*”
 - Text Information box at bottom of SOP amended: the following text in Breaths Information was removed: “without O₂ (until chest visibly rises)
(1 – 2 secs per breath if O₂ 100% until chest just begins to rise)
 - In “Subsequent / Rescue Breathing **10 –12** breaths per minute” was amended to **12** breaths per minute.

SOP 1A Closed

8. SOP 1B: The following amendments were decided upon:
 - “Breathing” text box “*absent or inadequate*” removed (not necessary).
 - Text box –“If none or inadequate...” removed and replaced with text over arrow “*No or inadequate*”
 - Text information box at bottom of SOP amended: the following text in **Breaths** was Included: “Inadequate, Consider when:
 - Respiratory rate outside normal breathing range
 - Gasping or grunting respirations, abnormal pattern of breathing
 - Associated bradycardia or cyanosis or
 - Reduced level of consciousness”
 - Circulation** Text Information box: amended to include:
 - “Accurate Clinical Assessment is essential”

SOP 1B Closed

9. SOP 1C: The following amendments were decided upon:
 - Text Box (left of **Airway - Open**)
 - “Head Tilt...**OPA/NPA.**” amended: **NPA** removed (not necessary)
 - “Breathing” text box “*absent or inadequate*” removed (not necessary).
 - Text box –“If none or inadequate...” removed and replaced with text over arrow “*No or inadequate*”
 - Circulation** Text Information Box at bottom of SOP the following sentence was Removed: “**Accurate clinical assessment is essential**” (not necessary).

SOP 1C Closed

10. Updated SOPs 1A, 1B, 1C to be distributed to MAG members on Thursday 14th Nov with 2 Day deadline for return approval / recommendation.

11. **Major Emergency / Incident(x 4):** Meeting to be arranged with
Brian Power,
Brian Abbott,
Lawrence Kenna,
Fergal Hickey,
Joe Foy,
Macartan Hughes
Major Incident SOPs to be discussed regarding the terminology to be used in them.
MIMMs terminology needs to be taken into consideration, to fit with Irish Terminology for
example Garda, Fire Crew etc.
12. **Neonatal Resuscitation SOP:** amended as attached
13. **SOP 3A:** Note taken of recommendation by Martin O'Reilly –
Cardiac Arrest (SOP) Advisory External Defibrillator – Adult
(Middle and Last columns) – after “no shock advised” circle, “Check Pulse – No
Pulse” should be included before as well as after “1 minute of CPR”. Referenced
from AHA documents. This point has been noted by MAG and will be addressed
as part of review of SOPs.
14. Database of points noted for SOP/AOP amendments/attention to be set up by MAG Support
Officer (Sharon Gallagher).
15. AOPs not discussed.
16. Next MAG Meeting date **to be decided** for December (preferably a Tuesday morning, not 4th
December – Clinical Audit Seminar).

Medical Advisory Group Meeting
Tuesday 11th December, 2001 10.30 am
Meeting Report

Present:

Macartan Hughes
Mark Doyle
Lawrence Kenna
John Burton
Joseph Foy
Patrick Plunkett
Julie Woods
Sean Creamer
Declan Lonergan

Apologies:

Colm Murphy
Stephen Cusack
Brian Abbott
Fergus McCarron
Michael Seaman
Kevin Flannery
Fergal Hickey
Noel Flynn
Vincent O'Connor
Tony Ryan
Vincent Cronly
Peter O'Connor
Gerard Bury
Connor Egleston

In Attendance:

Geoff King
Brian Power
Pauline Dempsey
Liz Dempsey
Sharon Gallagher

1. Minutes of MAG Meeting 13th November **Accepted.**
2. **SOP/AOPs** – ongoing discussion
3. Second PHECC Project Officer introduced to MAG – Pauline Dempsey. Ms Dempsey will look at structured framework on planned reviews of SOPs; issues arising from trainers/instructors in relation to SOPs etc. on behalf of MAG.
4. Noted that SOPs should have “Date Stamp” and annual/biennial review date. This review date should be sent to CAOs and Training Officers 3 months in advance. Where an immediate issue has to be amended then can do so through Chairs of MAG/Clinical Care.

5. **Disclaimer:** Concern was raised at MAG by lack of disclaimer associated with SOPs. Query from MAG to Council. Council to decide if 'Disclaimer' is required for SOPs.
6. Noted that MAG should look at implementation of SOPs on National Level.
7. Council to ratify letter to Chief Ambulance Officers regarding full SOP implementation and date in June 2002 (date in June also to be ratified by Council).
8. "Papers for consideration" for agenda items were distributed to members
9. National Examination 2002 – Presentation on developments to date by Mr Brian Power (Project Officer).

Process for dealing with skill lists decided:

- Skill lists to be circulated to training institutions to be reviewed
- Additional assistance to be employed by PHECC to further develop skill sheets.
- Theory assessment comparison – decided and agreed to have **IHCD** standards in relation to number of questions in all areas of exam.
- Recommended that resits should be considered for critical skills (example: 1 resit on 1 critical failure, depending on results from other areas)
- Recommended to have retrospective review every year on short questions and OSCE skills
- Decided - Examiners to be first to sit exam
- Above processes **to be agreed** as best practice in consultation with training Institutions and PHECC Committees.
- Turnaround time for each skill station to be decided – recommended 3 minutes
- Plan for PHECC to develop own independent question bank, this process could take up to three years.

To be carried forward – Failure of station results in failure of exam

10. EMT Examiners: 119 people on current list of examiners

Handout Amendments - "Draft – EMT Examiners":

- 1) "Potential have two or more of the following for **selection**;" "**selection**" replaced by "**consideration**".
- 2) "History of evidence of participation..." amended to "previous participation in EMT issues"
- 3) Draft to include in criteria for EMT Examiners – "currently on live registers of Medical, Nursing or EMTs"

MAG agreed on criteria list for Examiners including amendments above

11. **Legislation:** extracts as on handouts –

“**Misuse of Drugs Regulations, 1998 – S.I. No 328 of 1998**”

&

“**Medicinal Products (Prescription and control of Supply) Regulations, 1996 – S.I. No 256 of 1996**”

- Legislation issues on administration of drugs from above documents were discussed, status quo viewed as unacceptable, loopholes and shortcomings discussed
- Decided that legislation **should not** be looked for in regards to EMT administering drugs that **do not** have an SOP / Protocol.
- Agreed that administration of medicines should be in context of SOP / Protocol – indications and doses.
- Need to have broad legislation, official PHECC SOPs
- Qualification and insurance issues discussed

PHECC – to draft to MAG – framework of ideas for approaching legislation

Agreed – only EMTs on PHECC register would be included in legislation

Agreed that it was necessary to look at following items for legislation:

- EMT Personal qualifications
- Context in terms of SOPs/AOPs
- Working environment
- Professional capacity / insurance

12 **EMT database to NQEMT Register:**

Process discussed regarding transfers from EMT database to NQEMT register

Proposed official letter and information sheet that may be sent to EMTs in regard to transfer to NQEMT register should include following details:

- EMT qualifications
- Currently working as EMT
- Committed to best practice

Proposed that EMT to return letter signing off on above issues

The letter or Information sheet should state clearly what the EMTs are committing themselves to by signing on to register of NQEMT, and that they will give support to future professional development.

Note: 20% of EMTs already working in training /development – not on EMT Examiner database, could cause problem

PHECC will return to MAG more details of items to be included on letter.

13 **Building Capacity Project:** MAG members to read handout on project and review.

14 **Development of Training Proposal:** proposal distributed to MAG members Proposed as future agenda item

15. **Medical Advisory Group (MAG) Membership:** Extract from “Paper for consideration” discussed
It was agreed that representations need to be “locked” into position, agreed that “generic” aspects
Covered on MAG list.

Note: Situation on co-opting should issues come up

Suggested that there is a need for registered nurse on MAG

MAG List to be amended as follows: Mags Bourke - Medical Advisor for NATS
Peter O’Connor - Medical Advisor for NU

Terms of reference: streamline – in process (draft)

16. **Council and Committee member’s expenses:** for information only

- System to be set up by PHECC for expenses rates for PHECC staff and Committee members (Non-Council members) to be paid standard health board rates
- Council paid at higher rate
- All members of each Group/Committee will be written to explaining new procedure

- 17 **Any Other Business:**

A) Proposed Process of communicating SOP updates to Health Boards/Training Institutions

- Write to CAOs/EMTs who already have SOP manual, include with letter drafts of amended SOPs explaining that in June the updated republished SOPs will be forwarded to all.

B) Issue of Voluntary and Private Emergency Services and SOPs:

Workshop - flag issues there with SOP amendments

Public sector ambulances send out draft SOPs

C) PHECC to send:

- Letter to all CEOs copied to CAOs and Training/Development Officers regarding SOP
- Letter to CAO and Training/Development Officers with ***Draft SOP Amendments***

D) PHECC to examine options for printing of SOPs/AOPs – prices & length of time for publication
Process

E) PHECC to look at Voluntary / Private Sectors. MAG called for clarification regarding responsibility of PHECC for SOPs in relation to Private and Voluntary areas. Recommended that SOPs are used for reference and are only specific to qualified EMTs

F) Issue of Public Access Defibrillation:

- Legal opinion on what status is for use of defibrillators
- Involvement in models implemented
- Sponsorship – PHECC/Cardiovascular strategy
- Workshops – recommendations from public access defibrillation
- Find out what Voluntary Bodies situation is in relation to Defibrillators

G) Next MAG Meeting – National Examinations and Legislation to take priority in next MAG meeting

Next MAG Meeting: Tuesday 22nd January 10.30 am PHECC Office

7.0 Glossary of Terms:

The Chair requested members to examine the document conceptually and individually and to forward any feedback or recommendations to the PHECC Office over the coming weeks. The feedback will be collated from all members to form core discussion, members were requested as per previous July MAG meeting to engage in this process for next MAG meeting.

9.0 AOB

Head Injury – A document outlining definitions of head and maxillo facial on the PRF was distributed. A proposal to include maxillo facial injury as a category on the PRF was agreed.

Proposed: Dr Mags Bourke

Seconded: Mr John Burton

Burns Classification – A document outlining burns classifications on the PRF was distributed outlining uses of different classifications used in pre-hospital care/treatment. It was concluded that there was no good evidence for use of either “Wallace Rule of Nines”, “Palmar Surface” or “Lund and Browder” in pre-hospital setting.

The Chair outlined any research on this would be welcome and Mr Declan Lonergan agreed that he would look at the use of Lund and Browder classifications as are used in SEHB and present back to MAG at next meeting.

A brief paper on a Conceptual Model of Medical Oversight was distributed to members and they were requested to consider the concept in preparation for next MAG.

Date of next MAG meeting to be decided.

Signed:

Date:

Mr. Mark Doyle
Chair
