

Medical Advisory Committee

Meeting Minutes 8th June 2016

The Malton Hotel, Killarney

In attendance

Mick Molloy Chair
Niamh Collins
Martin O'Reilly
David Hennelly
Shane Mooney
Cathal O'Donnell
Macartan Hughes
Shane Knox
Eoghan Connolly
Ken O'Dwyer
David O'Connor
Derek Rooney
Michael Dineen
Conor Deasy

Apologies

David Menzies
Jack Collins
Peter O'Connor
Joseph Mooney
David McManus
Seamus McAllister
Gerry Kerr
Stephen Cusack
Neil Reddy
Declan Lonergan

Present

Brian Power PHECC
Jacqueline Egan PHECC
Margaret Bracken PHECC
Kathleen Walsh PHECC

1. Chair's Business

The Chair welcomed the members and noted that this was the last meeting of the committee as the term of the current Council concludes in June 2016. Apologies were noted. The Chair thanked all the members for their attendance, valuable contribution and feedback during the period of this committee. The Chair pointed out that the Department had not yet appointed a new Council. When appointed, the new Council will review the terms of reference of MAC and other committees. The Chair thanked Ms Jacqueline Egan for chairing the meeting on 26th May in the absence of the Chair and vice-Chair.

2. Draft Meeting Report – 26th May 2016

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

Matters arising:

Shane Mooney requested that he be added to the list of apologies which was not recorded in the minutes.

The members expressed their concerns that comments noted in the minutes regarding item 4.2 Palliative Care - Adult CPG were misrepresentative and could be misconstrued. Brian Power explained that some of the members had previously expressed dissatisfaction that some of their comments and issues were not recorded in the minutes of earlier meetings, and as a result of this all comments were minuted on this occasion. The members requested that the bulleted comments be removed and some of the wording be rephrased.

It was agreed to edit the last sentence to read 'Concerns were raised about the services, structures and the education specific to this, which are not currently in place'.

Item 4.3 Verification of Death CPG was highlighted. The consensus among the members was that the suggested timeframe recorded in the minutes of 'within three years' for review of the CPG and policy was inaccurate and should be changed to 'within one year of being enacted'.

David O'Connor sought clarification regarding item 5.2 Hypoglycaemia as a reversible cause of cardiac arrest and requested that the minutes be amended to state that 'Hypoglycaemia is not a reversible cause of cardiac arrest'.

Resolution: That the minutes of the Medical Advisory Committee 26th May be approved subject to the changes agreed.

Proposed: Michael Dineen

Seconded: Derek Rooney

Carried without dissent

3. Pre-hospital spinal injury management standard

A draft Pre-hospital spinal injury management standard and recommendations for MAC were included in the May meeting papers, and following substantial deliberation and feedback from the members amendments were made by Brian Power and included in the June meeting papers for further discussion.

There were concerns regarding the 3 types of risk factors and the question was raised if there should be a binary 'rule in' or 'rule out' system of high and low risk factors instead of a 3 tier system which includes 'minimal risk factors'. Clarification was sought on the difference between 'minimal' and 'low risk factors', and 'position of comfort'. After a robust discussion the general consensus was to simplify the risk factors and remove 'minimal risk factors'.

It was noted that an educational component will be required and that all Emergency Departments will need to be notified of the recommendations and accompanying CPGs to inform them of the change in practice. There was considerable discussion on each recommendation and additional amendments made as follows.

Pre-hospital spinal injury management - PHECC position paper

Introduction

It was agreed to add the word 'unselected' before 'penetrating trauma' to the last sentence in paragraph 3: 'Immobilisation of patients with unselected penetrating trauma is resulting in increased mortality and should cease is indicative for the need for change to current practice'.

Spinal injury

There were concerns expressed regarding the statement that 'injuries to the spinal column are uncommon in Ireland with 240 cases (62 with spinal cord injury) admitted to the National Spinal Injury Unit in 2014 (Mr Morris, Orthopaedic Surgeon, National Spinal Injury Unit)'. The general opinion among the members is that this evidence refers to a specific unit and is not an accurate reflection nationally. It was agreed to reword to include a national statistic for spinal cord injuries.

Current Recommendation 1:

Change terminology from 'spinal immobilisation to 'spinal motion restriction' when referring to the management of pre-hospital spinal injuries.

No change

Current Recommendation 2:

Following trauma should any of the following factors be present;

- dangerous mechanism of injury
- fall from a height of greater than 1 metre or 5 steps
- axial load to the head or base of the spine – for example diving, high-speed motor vehicle collision, rollover motor accident, ejection from a motor vehicle, accident involving motorised recreational vehicle, bicycle collision, horse riding accident, pedestrian v vehicle.
- age 65 years or older, with any of the above
- age 2 years or younger incapable of verbal communication, with any of the above

the patient should be regarded as 'high risk' and have active spinal motion restriction applied until assessment is complete

Updated Recommendation 2:

Following trauma should any of the following factors be present;

- dangerous mechanism of injury
- fall from a height of greater than 1 metre or 5 steps
- axial load to the head or base of the spine – for example diving, high-speed motor vehicle collision, rollover motor accident, ejection from a motor vehicle, accident involving motorised recreational vehicle, bicycle collision, horse riding accident, pedestrian v vehicle.
- Impaired awareness (alcohol/ drug intoxication, confused/ uncooperative or ALoC)
- age 65 years or older, with any of the above
- age 2 years or younger incapable of verbal communication, with any of the above

the patient should be regarded as 'high risk' and have active spinal motion restriction applied until assessment is complete

Current Recommendation 3:

Following trauma, if no high risk factors are present, and where any of the following factors are present;

- (i) involved in a minor rear-end motor vehicle collision
- (ii) comfortable in a sitting position
- (iii) ambulatory at any time since the injury
- (iv) no midline cervical spine tenderness
- (v) no immediate neck pain

and are able to actively rotate their neck 45 degrees to the left and right,

the patient should be regarded as 'low risk' and have passive spinal motion restriction applied until assessment is complete

Updated Recommendation 3:

Following trauma, if no high risk factors are present, and where any two or more of the following factors are present;

- involved in a minor rear-end motor vehicle collision
- comfortable in a sitting position
- ambulatory at any time since the injury
- no midline cervical spine tenderness
- no spinal column/ midline pain

and are able to actively rotate their neck 45 degrees to the left and right,

the patient should be regarded as 'low risk' and have passive spinal motion restriction applied until assessment is complete

Current Recommendation 4:

Following trauma should only one of the low-risk factors be present;

- involved in a minor rear-end motor vehicle collision
- not comfortable in a sitting position
- non ambulatory at any time since the injury
- no midline cervical spine tenderness
- no immediate neck pain

and

- are able to actively rotate their neck 45 degrees to the left and right,

the patient should be regarded as 'minimal risk' and not have spinal motion restriction applied

Delete current Recommendation 4

Current Recommendation 5:

Following a trauma assessment should a patient present with any of the following 'spinal injury rule in' considerations;

- any significant distracting injuries
- impaired awareness (alcohol/ drug intoxication, confused /uncooperative or ALoC)
- immediate onset of spinal/ midline back pain
- hand or foot weakness (motor issue)
- altered or absent sensation in the hands or feet (sensory issue)
- priapism
- history of past spinal problems, including previous spinal surgery or conditions that predispose to instability of the spine.
- unable to actively rotate their neck 45 degrees to the left and right (P & AP only)

or an appropriate assessment cannot be completed, a 'spinal injury rule in' shall be apply. Active spinal motion restriction shall thereafter be implemented until arrival at ED

Updated Recommendation 5 (now Recommendation 4):

Following a trauma assessment should a patient present with any of the following 'spinal injury rule in' considerations;

- any significant distracting injuries
- impaired awareness (alcohol/ drug intoxication, confused /uncooperative or ALoC)
- immediate onset of spinal/ midline back pain
- hand or foot weakness (motor issue)
- altered or absent sensation in the hands or feet (sensory issue)
- priapism
- history of past spinal problems, including previous spinal surgery or conditions that predispose to instability of the spine.
- unable to actively rotate their neck 45 degrees to the left and right (P & AP only)

or an appropriate assessment cannot be completed, a 'spinal injury rule in' shall apply. Active spinal motion restriction shall thereafter be implemented until arrival at ED

Current Recommendation 6:

Uncooperative patients shall not be forced into active spinal motion restriction as this is a greater risk to the patient.

No change (now Recommendation 5)

Current Recommendation 7:

Following a trauma assessment and in the absence of any of the following spinal injury rule in considerations;

- any significant distracting injuries
- impaired awareness (alcohol/ drug intoxication, confused /uncooperative or ALoC)
- immediate onset of spinal/ midline back pain
- hand or foot weakness (motor issue)
- altered or absent sensation in the hands or feet (sensory issue)
- priapism
- history of past spinal problems, including previous spinal surgery or conditions that predispose to instability of the spine.
- unable to actively rotate their neck 45 degrees to the left and right

passive spinal motion restriction should be implemented until arrival at ED.

Delete current Recommendation 7

Current Recommendation 8:

There is no requirement to carry out or maintain active or passive spinal motion restriction following trauma if patients:

- are deemed to have minimal risk factors
- do not present with any of the spinal injury rule in considerations
- are pain free and are able to actively rotate their neck 45 degrees left and right

No change (now Recommendation 6)

Current Recommendation 9:

If a decision is made, after the primary survey is complete and significant injuries stabilised, to continue active spinal motion restriction a rigid cervical collar may be considered at this point prior to lifting/moving the patient.

No change (now Recommendation 7)

Current Recommendation 10:

If mechanism of injury suggests a possible isolated lumbar or thoracic injury without cervical injury involved, cervical motion restriction is not indicated.

No change to current Recommendation 10, however reduce negative phrase in explanation.
(Now Recommendation 8)

Current Recommendation 11:

Patients with high or low risk factors and in the absence of any of the following spinal injury rule in considerations;

- any significant distracting injuries
- impaired awareness (alcohol/ drug intoxication, confused /uncooperative or ALoC)
- immediate onset of spinal/ midline back pain
- hand or foot weakness (motor issue)
- altered or absent sensation in the hands or feet (sensory issue)
- priapism
- history of past spinal problems, including previous spinal surgery or conditions that predispose to instability of the spine.

may be requested to self-extricate from a vehicle and be instructed to lie down on a trolley stretcher in a position of comfort.

Updated Recommendation 11 (now Recommendation 9)

Patients with high or low risk factors and in the absence of spinal rule in considerations may be requested to self-extricate from a vehicle and be instructed to lie down on a trolley stretcher in a position of comfort.

For patients not meeting these criteria use active spinal motion restriction practice for extrication.

Current Recommendation 12:

If a patient, with a suspected spinal injury, is ambulatory following trauma request the patient to lie down on the trolley stretcher if he/she is able to do so. If unable to comply consider alternative methods.

No change (now recommendation 10)

Current Recommendation 13:

Supine patients with suspected spinal injuries, where active spinal motion restriction is being continued, should be lifted with a split device in preference to a log roll.

No change (now recommendation 11)

Current Recommendation 14:

A long board is primarily an extrication device and should be used primarily for this purpose.

No change, however insert 'strongly' into explanation prior to 'discourage' (now Recommendation 12)

Current Recommendation 15:

The preferred mode for the transport of a patient with active spinal motion restriction is on a vacuum mattress. It is acknowledged that other options which suit the clinical needs of the patient may be used.

Updated Recommendation 15 (now Recommendation 13):

The preferred mode for the transport of a patient with active spinal motion restriction is on a vacuum mattress. It is acknowledged that other devices may be utilised.

Current Recommendation 16:

Patients presenting with penetrating trauma and no neurological signs should not have spinal motion restriction applied. Rapid transport to ED is essential to reduce mortality.

Updated Recommendation 16 (now Recommendation 14):

Patients presenting with isolated penetrating trauma and without neurological signs should not have spinal motion restriction applied. Rapid transport to ED is essential to reduce mortality.

Current Recommendation 17:

For patients with non-standard spinal anatomy i.e. ankylosing spondylitis, permit them to find a position where they are comfortable with manual spinal motion restriction. Non-standard methods such as rolled blankets may be utilised to accomplish spinal motion restriction.

Updated Recommendation 17 (now Recommendation 15):

For patients with non-standard spinal anatomy e.g. ankylosing spondylitis, permit them to find a position where they are comfortable with manual spinal motion restriction. Non-standard methods such as rolled blankets may be utilised to accomplish spinal motion restriction.

Current Recommendation 18:

When possible, the highest PHECC registered practitioner level on scene will determine if spinal motion restriction is to be used or discontinued i.e. cease active spinal motion restriction

No change (now recommendation 16)

Current Recommendation 19:

Paediatric patients following trauma should be assessed for spinal injury using the 'spinal injury rule in' considerations.

Updated Recommendation 19 (now recommendation 17):

Paediatric patients following trauma should be assessed for spinal injury using the 'spinal injury rule' in considerations.

Current Recommendation 20:

**The preferred mode for the transport of a paediatric patient with active spinal motion restriction is on a vacuum mattress or appropriately sized vacuum device. It is acknowledged that other options which suit the clinical needs of the patient may be used.
Non-standard methods such as rolled blankets may be utilised to accomplish spinal motion restriction.**

Updated Recommendation 20 (now recommendation 18):

**The preferred mode for the transport of a paediatric patient with active spinal motion restriction is on a vacuum mattress or appropriately sized vacuum device. It is acknowledged that other options may be used.
Non-standard methods such as rolled blankets may be utilised to accomplish spinal motion restriction.**

Current Recommendation 21:

Manual spinal motion restriction should be provided if the child is distressed or uncooperative.

Updated Recommendation 21 (now Recommendation 19):

Uncooperative paediatric patients shall not be forced into active spinal motion restriction as this is a greater risk to the patient.

Current Recommendation 22:

Very young conscious paediatric patients with suspected spinal injury may have spinal motion restriction applied using the child's own car seat if it is intact following a collision, however they should not be forced into this position.

No change (now Recommendation 20)

Current Recommendation 23:

- (i) EMTs shall provide active spinal motion restriction for all patients with any 'spinal injury rule in' considerations whether or not 'High Risk', 'Low Risk' or 'Minimal Risk' factors are present.**
- (ii) EMTs shall provide active spinal motion restriction for all patients, in the absence of any of the 'spinal injury rule in' considerations and with 'High Risk' or 'Low Risk' factors present.**
- (iii) EMTs may consider no spinal motion restriction in the absence of any of the spinal injury rule in considerations and with only 'Minimal Risk' factors present.**

Updated Recommendation 23 (now Recommendation 21):

EMTs shall provide active spinal motion restriction for all patients with 'High Risk' or 'Low Risk' factors present even in the absence of any of the spinal injury rule in considerations.

Current Recommendation 24:

Recommendations 1, 2, 5, 6, 9, 12, 13, 14, 15, 16, 17, 19, 20, 21 and 22 shall apply to EMTs when managing suspected spinal injury.

Updated Recommendation 24 (now recommendation 22):

Recommendations 1, 2, 4, 5, 7, 10, 11, 12, 13, 14, 15, 17, 18, 19 and 20 shall apply to EMTs when managing suspected spinal injury.

Current Recommendation 25:

While waiting for the arrival of a practitioner Responders shall provide active spinal motion restriction for all patients if 'High Risk' or 'Low Risk' factors are present.

No change (now Recommendation 23)

Current Recommendation 26:

Responders at FAR/ OFA level should maintain the patient, with suspected spinal injury, in the position found while maintaining active spinal motion restriction.

No change (now Recommendation 24)

Current Recommendation 27:

Responders at EMR level should consider returning the head to neutral position (unless pain or resistance increases) and maintain active spinal motion restriction if spinal injury is suspected.

Updated Recommendation 27 (now Recommendation 25):

Responders at EFR level should consider returning the head to neutral position (unless pain or resistance increases) and maintain active spinal motion restriction if spinal injury is suspected.

Current Recommendation 28:

Responders at EFR level, who are operating on behalf of a licenced CPG provider, may apply a cervical collar while maintaining active spinal motion restriction to facilitate extrication.

No change (now Recommendation 26)

Current Recommendation 29:

Responders at EFR level, who are operating on behalf of a licenced CPG provider, may extricate a patient on an appropriate device in the absence of a practitioner if;
(i) An unstable environment prohibits the attendance of a practitioner, or
(ii) While awaiting the arrival of a practitioner the patient requires rapid extrication to initiate emergency care

No change (now Recommendation 27)

Current Recommendation 30:

Responders at EFR level, who are operating on behalf of a licenced CPG provider, if waiting for an ambulance response should remove an extricated patient from an extrication device and secure into a transport device.

Updated Recommendation 30 (now Recommendation 28):

Responders at EFR level, who are operating on behalf of a licenced CPG provider, if waiting for an ambulance response may remove an extricated patient from an extrication device and secure into a transport device.

Current Recommendation 31:

Responders at EFR level, who are operating on behalf of a licenced CPG provider may request a patient, with a suspected spinal injury, who is ambulatory following trauma to lie down on a trolley stretcher or other device if he/she is able to do so. If unable to comply consider alternative methods.

No change (now Recommendation 29)

Current Recommendation 32:

Responders at EFR level, who are operating on behalf of a licenced CPG provider following the provision of spinal injury management, shall complete an Ambulatory Care Report (ACR) or Patient Care Report (PCR) and present the top copy to the practitioner transporting the patient to ED.

No change (now Recommendation 30)

Current Recommendation 33:

Recommendations 1, 2, 5, 6, 13, 14, 16, 17, 19, 21 and 22 shall apply to EFRs operating on behalf of a licenced CPG provider when managing suspected spinal injury.

Updated Recommendation 33 (now recommendation 31):

Recommendations 1, 2, 4, 5, 11, 12, 14, 15, 17, 19 and 20 shall apply to EFRs operating on behalf of a licenced CPG provider when managing suspected spinal injury.

Resolution: That position paper on pre-hospital spinal injury management be recommended to Council as the standard of care subject to the changes outlined above.

Proposed: Eoghan Connolly
Carried by dissent

Seconded: Niamh Collins

4. CPG updates

4.1 Spinal injury management CPGs

There was considerable deliberation among the members on the spinal injury management CPGs. The CPGs were modified to reflect the recommendations agreed in the pre-hospital spinal injury management position paper.

Brian Power informed the members that a considerable amount of work was executed by the spinal injury subgroup and the CPGs were modeled on their findings and based on the NICE Guidelines and best practice.

5/6.6.9 Spinal Injury Management

The following changes were agreed.

- Rearrange the order of boxes on right and edit as follows:
 1. High risk factors
 - add '- any of the following'
 - add new bullet point 4 - 'impaired awareness (alcohol/drug intoxication, confused/uncooperative or ALoC)'
 2. Low risk factors
 - add '- any two or more of'
 - bullet point 5 - replace 'no immediate neck pain' with 'no spinal column/midline pain'
 - 'And are able to actively rotate their neck 45 degrees to the left and right' not to be included in the list of two or more – bold **And**
 3. Spinal injury rule in considerations
 4. PHECC Spinal Injury Management Standard
 - Passive spinal motion restriction: replace 'lie on a trolley stretcher in' with 'adopt' to read '.....permitting the patient to adopt a position of comfort'.
 5. Remove Minimal risk factors
- After 'Trauma and concern by practitioner of spinal injury' insert a new box: 'Manual in-line stabilisation until clinical assessment is complete'
- Remove boxes: 'Minimal risk factors', 'Immobilisation may not be indicated', 'Go to appropriate CPG'
- After 'Passive spinal motion restriction' add 'or spinal motion restriction may not be indicated' and change to grey box
- Reference: update to STN 024 Version 1

Recommendation: That CPG 5/6.6.9 Spinal Injury Management be recommended to Council for approval subject to the changes agreed.

Proposed: Niamh Collins
Carried without dissent

Seconded: Shane Mooney

4.6.9 Spinal Injury Management

Changes made as per CPG 5/6.6.9 outlined above.

Recommendation: That CPG 4.6.9 Spinal Injury Management be recommended to Council for approval subject to the changes agreed.

Proposed: Michael Dineen
Carried without dissent

Seconded: Ken O'Dwyer

2/3.6.9 Spinal Injury Management

- Add red box 'Low risk factors' to right and edit 'Spinal injury rule in considerations' box as per EMT CPG 4.6.9
- Move box on left 'Do not forcibly restrain a patient that is combative' to end of CPG
- After telephone
 - add a right arrow and insert new box 'advise patient to remain still until arrival of a higher level of care'
 - after left arrow insert circle with FAR flag; edit box 'Return head to neutral position.....(insert 'an' in front of increase)'; delete EFR flags
- Reference: update to STN 024 Version 1

Recommendation: That CPG 2/3.6.9 Spinal Injury Management be recommended to Council for approval subject to the changes agreed.

Proposed: Ken O'Dwyer
Carried without dissent

Seconded: Michael Dineen

5. 2016 Medication Formulary

A draft copy of the Medication Formulary for Practitioners 2016 was included in the meeting papers for information. Brian Power explained that edits and updates are being carried out and he requested the members to email comments and feedback to him for consideration.

An email with feedback to Brian Power from Jack Collins, who was unable to attend the meeting, was tabled and included for discussion. Brian Power will update the formulary to reflect these comments.

Recommendation: That the 2016 Medication Formulary be recommended to Council for approval subject to sign off by the PHECC Medical Director, Dr Mark Doyle.

Proposed: Shane Mooney
Carried without dissent

Seconded: Shane Knox

6. ACR Information Standard 2016

A draft copy of the PHECC ACR Information Standard 2016 was handed out to each member present at the meeting, and a differences table with the current 2013 edition was included in the meeting papers.

Ms Jacqueline Egan, PHECC Programme Development Officer, briefed the members with an overview of the differences.

The feedback from the members was very positive. The question was asked if 'MCRN' is correct for recording the registered number used by doctors and Ms Egan agreed to clarify this with the Medical Council. There was a proposal to include more space on the ACR Form to add additional notes.

Recommendation: That the PHECC ACR Information Standard 2016 be recommended to Council for approval.

Proposed: Mick Molloy
Carried without dissent

Seconded: Derek Rooney

7. Terms of Reference for future MAC

The terms of reference and membership of the Medical Advisory Committee was discussed. Brian Power informed the members that the new Council will review the terms of reference and may change the structure of future committees in addition to the recommendations from this present committee. There were many suggestions and proposals from the members.

It was suggested to possibly reduce membership of the Committee to 10-12 as smaller groups can be more effective, large groups cannot be catered for in the PHECC office and have to be held off-site, also coordinating and chairing larger groups can prove difficult. Concerns were voiced that quality may be compromised because of the high volume of work involved, a lot of preparation and attendance at meetings has to be done voluntarily on the member's own time. The suggestion of setting up an expert group to meet twice a year was discussed. The general opinion among the members is not to reduce the number of committee meetings.

It was considered if it is necessary to have 3 clinical levels on the committee and if this adds value. The consensus among the members is that practitioner involvement is very important and necessary. It is also noted that the Delphi process needs to be strengthened to include optimum feedback from all members. The voting system was deliberated with concerns about multiple nominations from a single Service. Brian Power clarified that it is immaterial how many members are from the same Service.

As the members have to be present themselves at meetings and cannot send a replacement this can create difficulties for them.

A proposal was made to change the name of the committee to the Clinical Advisory Committee. There were suggestions that perhaps the MAC should consist of members at clinical level only and the Education and Standards Committee be composed mainly of members at educational level. The general opinion was that the educational role of the MAC is very important, valuable, and necessary for the production of high quality and comprehensive work. A recommendation to add a University representative to the membership was made.

Brian Power requested the members to email to him any further comments and suggestions from a clinical and policy basis to present to the new Council for consideration.

8. AOB

Paediatric Intubation was discussed and it was agreed to put a standard and CPG in place for this using the Queensland Service Model, to be discussed and reviewed by the future MAC. In the meantime Brian Power will consult with Dr Mark Doyle, Dr Cathal O'Donnell, and Dr Peter O'Connor.

Resolution: That a draft standard and CPG for paediatric intubation be developed for review by the next Medical Advisory Committee and Council.

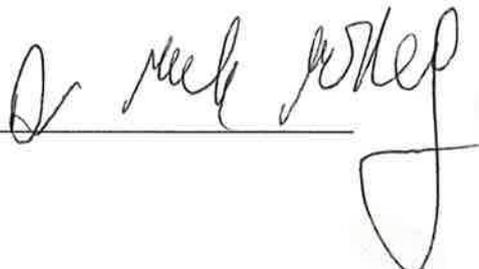
Proposed: Macartan Hughes
Carried with dissent

Seconded: David Hennelly

The members requested that teleconference dial-in details be made available for future meetings.

Brian Power thanked the Chair, the vice-Chair, the members of MAC and the PHECC executive for all their hard work over the term of the committee. He especially wished to acknowledge the painstaking work of Ms Margaret Bracken and her predecessor Ms Deirdre Borland in preparing meeting papers and drafting minutes. He highlighted the valuable contribution made by MAC to the development of pre-hospital emergency care in Ireland.

The meeting concluded.

Signed:  Date: 20/7/16