Pre-Hospital Emergency Care Council

The Medical Advisory Committee

Meeting Minutes November 28th 2013

PHECC Office, Naas, Co. Kildare

Present		**Apologies**
Niamh Collins	Seamus McAllister	Valerie Small
Gerry Kerr	David O'Connor	Derek Rooney
Peter O'Connor	Ken O'Dwyer	Shane Mooney
Jack Collins	Joseph Mooney	Neil Reddy
Martin O'Reilly	Declan Lonergan	Sean Walsh
Macartan Hughes	Dave Irwin	Mick Molloy
Cathal O'Donnell	Michael Dineen	Seamus Clarke
David Hennelly		**In Attendance**
Shane Knox		Brian Power
David Menzies		Deirdre Borland

1. Chair's business

The Chair welcomed the assembled members and apologies were noted including those of the Chair Mick Molloy. Seamus McAllister from the NAIS was also welcomed. In the absence of the Chair, the Vice-Chair Niamh Collins chaired the meeting.

2. Draft Meeting Report – 31st October 2013

Resolution: That the minutes from the Medical Advisory Committee meeting held on the 31st October 2013 be agreed.

Proposed: Joseph Mooney Seconded: Peter O'Connor

Carried without dissent

2.1 Matters Arising

2.1.1 Garda tactical Emergency Care Course

Brian Power informed the group that Council had raised some concerns regarding the skills suggested for and the duration of the proposed Garda tactical Emergency Care Course. They have asked that a Tactical Emergency Care Standard be developed and be brought back to Council.

2.1.2 Ticagrelor

Brian Power contacted Prof Daly regarding the concerns raised at the last MAC regarding the administration of Ticagrelor with bradycardia present; he is awaiting a definitive response.

David Hennelly indicated that haven spoken to numerous cardiologists the general opinion does not have any issue with the loading dose of Ticagrelor. Brian will await further instruction from Prof Daly. Brian Power indicated that an interim directive would be required, as Ticagrelor is not currently on the 7th schedule.

2.1.3 Brian Power has identified Dr Corrina McMahon, haematologist, as an appropriate person to get advice on regarding the sickle cell and g6pd CPG and revert back to a future meeting when the issue is clarified.

3. CPGs

3.1 Paediatric age range

Brian Power informed the group that Prof. Alf Nichloson, Clinical Lead for Paediatrics, has advised that the age range for paediatric doses is agreed nationally as "up to the eve of the child's 16th birthday", he asked that the Committee agreed to amend all Paediatric CPGs to reflect this.

Cathal O'Donnell raised a concern that some hospitals use the age limit of 14 years and this should be taken into account. David Menzies suggested that the CPGs generally will not impact on destination hospital and that it is an operational issue.

Resolution: That the Medical Advisory Committee recommends to Council that the new cut off age for paediatric patients of ≤15 years old be adopted and that all paediatric CPGs be updated to reflect this change.

Proposed: Michael Dineen **Seconded:** Peter O'Connor

Carried without dissent

3.2 Heat Related Emergency – Adult

Draft CPG 4/5/6.6.10 Heat Related Emergency – Adult was included in the meeting papers for the Committees attention.

Resolution: That the Medical Advisory Committee recommends to Council approval of 4/5/6.6.10 Heat Related Emergency – Adult.

Proposed: Joseph Mooney Seconded: Macartan Hughes

Carried without dissent

3.3 Pyrexia – Paediatric

Macartan Hughes raised a concern regarding the availability of PR paracetamol. Shane Knox informed the Committee that a 90 mg suppository is now on the market. Draft CPG 4/5/6.7.19 Pyrexia – Paediatric was included in the meeting papers for the Committees attention.

Resolution: That the Medical Advisory Committee recommends to Council approval of CPG 4/5/6.7.19 Pyrexia – Paediatric.

Proposed: Peter O'Connor Seconded: Declan Lonergan

Carried without dissent

3.4 Acute Pulmonary Oedema

Draft CPG 5/6.3.4 Acute Pulmonary Oedema was included in the meeting papers for the Committee's attention. An email from Seamus Clarke with a concern regarding "Systemic Fluid Retention" was tabled for discussion. It was agreed that this was a training issue. The Chair asked that the 12 lead ECG box should lead to the option of ACS CPG if STEMI was identified, this does not impact on the requirement for CPAP. She also asked that the dose of Atropine be stated at 0.6 mg to avoid issues around drawing up. Macartan Hughes informed the group that dose of active ingredient is only 0.5 mg of Atropine. Discussion ensued regarding the dose/active ingredient concentration. It was agreed to amend the dose to 0.6 mg. It was also agreed to commence CPAP of H_20 at 5 cm. The Chair also suggested that "improvement in respiratory rate and SpO_2" be amended to "titrate O_2 to maintain SpO_2 >95%".

It was suggestion that agitation should be removed from the exclusion criteria and replaced with "unable to tolerate CPAP" It was agreed to remove "with no evidence of infection" from the inclusion criteria.

Resolution: That the Medical Advisory Committee recommends to Council approval of CPG 5/6.3.4 Acute Pulmonary Oedema subject to the agreed changes.

Proposed: David Hennelly Seconded: Macartan Hughes

Carried without dissent

3.5 Shock from Blood Loss – Adult

Draft CPG 5/6.6.2 Shock from Blood Loss – Adult was included in the meeting papers for the Committees attention. Brian Power informed the Committee that in the absence of a Chief Pharmacist to ratify the amendments to the Medicinal Products 7th schedule, Tranexamic acid would take considerable time to be included on the schedule. With the strength of evidence supporting Tranexamic acid following multisystem trauma it could not be justified to wait any longer. Tranexamic acid can be made available by way of interim directive. David Hennelly asked that consider pelvic binder be included for polytrauma patient and consider maintain normothermia, this was agreed. He also asked that a pre-alert hospital if appropriate be included. David Menzies asked that Tranexamic acid be administered in 100 mL of saline over 10 mins rather than 1 mg slow IV. Shane Knox said that JRCALC list head injury as a contraindication for Tranexamic acid. It was agreed that a caution box be included in the medication formulary for isolated head injury. It was suggested that uncontrolled haemorrhage be changed to suspected significant internal/external haemorrhage. Brian Power pointed out the inclusion of the Tranexamic Acid for use by Advanced Paramedics requires a signed interim directive in place. Macartan Hughes requested trauma be included in the title of the CPG, and to develop a 2nd CPG for non-traumatic shock. It was agreed that two CPGs were appropriate. It will be retiled to Shock from Blood Loss (Trauma) Blood Loss – Adult, and develop a 2nd CPG in parallel called Shock from Blood Loss (non – trauma) – Adult.

Resolution: That the Medical Advisory Committee recommends to Council approval of CPG 5/6.6.2 Shock from Blood Loss (Trauma) Blood Loss – Adult, subject to the agreed changes.

Proposed: Declan Lonergan Seconded: Michael Dineen

Carried without dissent

Resolution: That the Medical Advisory Committee recommends to Council approval of CPG Shock from Blood Loss (non – trauma) – Adult, subject to the agreed changes.

Proposed: Macartan Hughes Seconded: Peter O'Connor

Carried without dissent

3.6 Shock from Blood Loss – Paediatric (≤ 13 years)

Draft CPG 5/6.7.13 Shock from Blood Loss – Paediatric (≤ 13 years) was included in the meeting papers for the Committees attention. It was agreed that the changes agreed for the Adult CPG be reflected here. David Menzies questioned the administration on Tranexamic acid for children aged

under 12 as the Royal College of Paediatrics and Child Health only suggests it for over 12 years. Brian Power referenced JRCLAC who provide age doses for children from neonate upwards. It was agreed to refer this to Sean Walsh for his expert opinion. David Hennelly informed the Committee that IO administration is not approved, Brian Power indicated that evidence suggests it is possible to administer IV/IO. The Chair asked that the signs of poor profusion be presented in an ABC format.

Resolution: That the Medical Advisory Committee recommend to council two CPGs; Blood Loss (trauma) Blood Loss – Paediatric and Shock from Blood Loss (non – trauma) – Paediatric, with the changes outlined in the Adult CPG. Subject to the agreement of Sean Walsh OLHC.

Proposed: Peter O'Connor Seconded: David Hennelly

Carried without dissent

3.7 CPG Delphi

Brian Power introduced the feedback from the Delphi process. He stressed the importance of all MAC members taking part with the Delphi process.

3.7.1 Sickle Cell Crisis – Paediatric

Delphi feedback from Draft CPG Sickle Cell Crisis – Paediatric was discussed. Cathal O'Donnell asked that importance of rehydration be of greater focus. Dave Irwin indicated the he felt the CPG was adequate. David Hennelly questioned that a time limit may be required for Entonox administration. Brian Power suggested that this caution could be captured in the Medication Formulary. Macartan Hughes suggested the entry into the CPG be changed to "sickle cell crisis", that 100% O_2 be flagged and to move down the SpO_2 monitor box. It was agreed that "consider patients care plan" will be included.

Resolution: That the Medical Advisory Committee recommends to Council approval of Draft CPG Sickle Cell Crisis – Paediatric subject to the agreed changes.

Proposed: Ken O'Dwyer Seconded: Joseph Mooney

Carried without dissent

3.7.2 Sickle Cell Crisis – Adult

Delphi feedback from Draft CPG Sickle Cell Crisis – Adult was discussed. The chair suggested that the fluids should be increased to 1 L and that the changes from the paediatric CPG be incorporated.

Resolution: That the Medical Advisory Committee recommends to Council approval of Draft CPG Sickle Cell Crisis – Adult subject to the agreed changes.

Proposed: Dave Irwin Seconded: David O'Connor

Carried without dissent

3.7.3 Tachycardia – Adult

Delphi feedback from Draft CPG Tachycardia – Adult was discussed. David Menzies suggested that given the level of disagreement this CPG may warrant further attention. The Chair asked the practitioners what is the frequency of Tachycardia. David Hennelly said that there was a significant number of A Fib. He further said that the SVT or VT patients could benefit from the Tachycardia CPG. David Menzies suggested a split into stable and unstable tachycardia. Macartan Hughes asked it the frequency of occurrence of these cases merits the creation of a CPG. A discussion ensued in regard to the feedback submitted. Brian Power suggested concentration on wide complex, unstable patients with VT should be wise. It was agreed that Brian Power will look at the IHF Algorithm and develop the CPG with the interventions such as Amiodarone for VT patients, Synchronised Cardio version for unresponsive VT patient and Vagal/Valsalva manoeuvres for patients with PSVT

3.7.4 Adrenal Crisis – Adult

Delphi feedback from Draft CPG Adrenal Crisis – Adult was discussed. Feedback received was discussed. The following changes were agrees:

- title box be changed to Adrenal insufficiency – Adult
- entry box to state Diagnosed with Addison's disease or adrenal insufficiency
- IM administration of hydrocortisone only if IV access unavailable
- Inclusion of blood glucose check
- Hydrocortisone to be administered in 100 mL NaCl

Resolution: That the Medical Advisory Committee recommends to Council approval of Draft CPG Adrenal Crisis – Adult subject to the agreed changes

Proposed: David Menzies Seconded: Cathal O'Donnell

Carried without dissent

3.7.5 Adrenal Crisis – Paediatric

Delphi feedback from Draft CPG Adrenal Crisis – Paediatric was discussed. It was agreed to change the paediatric CPG as per the agreed adult changes.

Resolution: That the Medical Advisory Committee recommends to Council approval of Draft CPG Adrenal Crisis – Paediatric subject to the agreed changes

Proposed: Dave Irwin Seconded: David Menzies

Carried without dissent

3.8 New CPGs for review

3.9.1 Fainting

A first draft of Responder Level CPG Fainting was introduced by Brian Power. He indicated that this is a new CPG and will have to go through a Delphi process. Brian outlined that with the introduction of the new Emergency Care Standard a fainting CPG is required. He stated that first aid books appeared to neglect the potential seriousness of fainting and never suggested medical review. He welcomed the Committees feedback. Cathal O'Donnell asked that the box advising the person to attend a medical practitioner be moved out of the algorithm to an advice box at the side.

4. Practitioner queries re CPGs and medications

4.1 Hexafluorine and Diphoterine

Brian Power introduced information sheets on Hexafluorine and Diphoterine used for the topical treatment of chemical burns. He asked for the Committees consideration to add these agents to the Burns CPG. A discussion arose regarding the frequency of chemical burns and the shelf life of the product. It was agreed, while noting these agents are beneficial, they very low frequency of occurrence and that organisation who use chemicals shock these or similar products as part of their safety requirements, it would not be necessary to stock these items as part of a pre-hospital emergency care response. Brian Power indicated that as these agents were not medicinal products they did not require to be added to the 7th schedule. Martin O'Reilly advised that because of the clarification from MAC regarding Hexafluorine and Diphoterinedue the fact that they are not medications and as such not bound by medications legislation, DFB will be in a position to decide whether to carry these solutions on that basis.

4.1 GTN and EFRs

An email from David Menzies seeking clarification on the assisted administration of GNT by EFRs was included in the meeting papers. The current situation is that EFRs may assist with only one dose of GTN. The question is can an EFR assist in the administration of more than one dose of GTN. Peter O'Connor suggested leaving as is and that the EFR should seek doctor's direction, of allow the patient take their own further doses. This was agreed by those present.

5 Ambulatory care report (ACR) information standard.

A revised Information Standard for the Ambulatory Care Report was included in the meeting papers for the Committees review and sought the committee's approval of the Standard.

Resolution: That the Medical Advisory Committee recommends to Council approval of the revised Ambulatory Care Report Information Standard

Proposed: Joe Mooney Seconded: Jack Collins

Carried without dissent

6 Briefing from Respiratory emergencies CPG sub group

This item will be discussed at the next meeting

7 Briefing from Sepsis CPG sub group

This item will be discussed at the next meeting

8 KPI Update

This item will be discussed at the next meeting.

9 A.O.B

9.1 A report from the OHCAR group giving the highlights of the ERC Resus symposium in Krakow was included the meeting papers. The committee will seek further information from Siobhan Masterson regarding the data on resuscitation post trauma figures.

9.2 Dave Irwin raised a query from an EMT working in for a voluntary organisation regarding the medication and skills matrix. He asked if the skills indicated at Paramedic level could be taught to EMTs. Brian Power informed him that the skills matrix specifies the minimum skills required at each level and there is nothing prohibiting a CPG approved organisation in offering skills training above the minimum requirements to its members. Brian further advised that should a CPG approved organisation increase the scope of practice for its members then they are responsible to ensure competence is maintained by the responders and practitioners. In the event of a claim of negligence PHECC will stand over the official scope of practice but the CPG approved organisation will have to justify why it was necessary to increase the scope of practice beyond PHECC's standard. Brian did caution that medications listed on the matrix are authorised by way of statutory instrument (7th Schedule) and are strictly authorised for the indicated clinical level.

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The next meeting will be held on 30th of January 2014

Signed: _____ Date: 30/1/14