Pre-Hospital Emergency Care Council

Medical Advisory Committee Meeting

24th September 2015

Osprey Hotel, Naas

In attendance	Apologies	Present
Niamh Collins	Mick Molloy	Brian Power
Seamus McAllister	Joe Mooney	Margaret Bracken
Conor Deasy	Shane Mooney	Peter Dennehy
David Hennelly	Peter O'Connor	
Macartan Hughes	Gerald Kerr	
Shane Knox	David McManus	
Declan Lonergan	Michael Dineen	
David O'Connor	Jack Collins	
Derek Rooney	Martin O'Reilly	
Cathal O'Donnell		
David Menzies		

1. Chair's Business

The vice chair welcomed the members and apologies were noted; including those of the Chair. The committee welcomed Mr Peter Dennehy, Director of PHECC, to the meeting.

Mr Dennehy addressed the meeting and spoke about how far the profession has come and commended everybody on their hard work to date.

2. Minutes and matters arising

Niamh Collins requested an amendment to the minutes: 3.1.7

after Ketamine change from 'be in a structured limited rollout' to 'be explored'

Resolution: That the minutes of the Medical Advisory Committee Thursday 25th June be approved, subject to the agreed change.

Proposed: Derek Rooney **Seconded:** Declan Lonergan

Carried without dissent

3. CPGs

Dr Katie Padfield – Experiences with Ketamine:

The vice chair introduced Dr Katie Padfield to the committee. Katie has extensive experience using Ketamine both in Sudan and the Royal Flying Doctors in Australia. In Sudan Ketamine was used for operations without advanced airway adjuncts. Katie thanked Brian for inviting her and spoke about her experiences with Ketamine. In her opinion Ketamine can be safely used for analgesia and sedation when administered in low doses (0.1 mg/kg) and as a very good anaesthetic when administered in high doses (1 to 1.5 mg/kg). Although patients may seem distressed during procedures they have no memory of this afterwards. There is a chance of anaesthetic reaction after a high dose but the reaction is not aggressive and there is no increased risk to practitioners. She suggested introducing it as an analgesic initially.

1.1 mg/kg for analgesia
1-1.5 mg/kg for anaesthetic/sedation

David Menzies and Conor Deasy have experience using the medication and gave their opinions:

David Menzies – should be considered for non-traumatic pain. PHECC should have a CPG for sedation and Ketamine would be suitable should higher doses of morphine be available.

Conor Deasy – Ketamine when administered correctly is far safer than some of the medications we currently have. It does not need massive amounts of training but a lot of awareness is needed. 10 mg of Ketamine when max of morphine reached, will not affect respiration or blood pressure – side effect nausea and vomiting have to be considered.

Other comments include:

- Very different medication, need a very robust education and training standard around it. The practitioner has to be confident using it.
- Was concerned that using the medication would present difficulties for pre-hospital patients, especially if the patient becomes distressed in the back of the ambulance.
- It was suggested to use a combination of Fentanyl and Ketamine for short term procedures such as extrication or limb alignment.

Resolution: That Ketamine be introduced into the PHECC medication formulary for pain management and sedation.

Proposed: David Hennelly **Seconded:** Conor Deasy
Carried without dissent

3.1 CPGs Delphi report

Brian Power expressed his disappointment on the poor response to the report with total response of 58.6% of MAC members.

- **External Haemorrhage – Adult (4/5/6.6.3)**

Apply scalp clips for temporary closure for haemorrhage control:
There was some opposition to using scalp clips and a few members are unsure. The consensus was that CPG is to be revised at a later meeting having explored it more. Consult with Queensland Ambulance Service as they have a CPG for this.

"Posture Elevation Examination Pressure" to be moved and placed before catastrophic haemorrhage.

Depress proximal pressure point – add EMT level.

- **External Haemorrhage –Paediatric (4/5/6.7.50)**

The changes and comments as per Adult CPG apply to this CPG also.

- **Glycaemic Emergency – Adult (Practitioner) (4/5/6.4.19)**

Insert "Consider ALS" to after Conscious/able to swallow (No)
Repeat prn: change from P TO EMT (Glucose gel 10-20 g buccal)

Resolution: that the Medical Advisory Committee recommend the Glycaemic Emergency – Adult (4/5/6.4.19) CPG to Council for approval, subject to the agreed changes.

Proposed: Macartan Hughes **Seconded:** Derek Rooney
Carried without dissent

- **Glycaemic Emergency – Responder (2/3.4.19)**

No changes were recommended to the draft CPG.

Resolution: That the Medical Advisory Committee recommend Glycaemic Emergency – Responder (2/3.4.19) to Council for approval.

Proposed: David Menzies **Seconded:** Shane Knox

Carried without dissent

- **Actual/Potential Shock from Blood Loss (trauma) – Adult (5/6.6.8)**

Insert care bundle - pelvic splint box

Change initial fusion of NaCl (0.9%) 500 mL IV/IO to "consider administration of 250 mL IV if clinical signs of shock"

Resolution: that the Medical Advisory Committee recommend CPG Actual/Potential Shock from Blood Loss (trauma) – Adult (5/6.6.8) to Council for approval, subject to the agreed changes.

Proposed: David O'Connor **Seconded:** David Hennelly

Carried without dissent

- **Tachycardia –Adult**

The consensus was that there was a lot of information in this CPG and to come back to review again after the 2015 ILCOR release.

3.2 CPGs updated

3.2.1 Draft CPG Pain Management Adult (4/5/6.2.6) & Paediatric (4/5/6.7.5)

It was agreed that Ketamine is appropriate for inclusion on CPG

Change to 0.1 mg/kg IV with repeat Ketamine once at 5 min interval (< 50kg = 5 mg; > 50 kg = 10 mg)

The indication for Ketamine was agreed as; intractable pain where other medications have not been effective or temporary necessary movement may result in significant pain.

It was suggested to improve layout of Pain Ladder; that the Queensland Model could be considered and to remove 3D effect.

It was suggested to insert "anticipated pain" in red box at end of CPG.

On Paediatric CPG remove information box "Tramadol PO for >12 year olds only".

3.2.2 Draft CPG Anaphylaxis Adult (4/5/6.4.15)

Within box "Epinephrine administered pre arrival?" insert "effective".

The agreed spelling of Chlorphenamine to be used throughout.

It was suggested that subject to changes outlined that this CPG go to Delphi.

3.2.3 Draft CPG Anaphylaxis Paediatric (4/5/6.7.31)

Changes as per Adult CPG.

Insert a box - Consider Oral antihistamine Valergan? Consult with Dr Sean Walsh.

Consult with Department of Health on use of non-licensed medications.

3.2.4 Draft CPG Seizure Adult (5/6.4.23)

No changes were recommended and it was agreed that this CPG could go to Delphi.

3.2.5 Draft CPG Seizure Paediatric (5/6.7.33)

No changes were recommended and it was agreed that this CPG could go to Delphi.

3.3 Sepsis Adult CPG (4/5/6.4.24)

Change > 39°C to 38.3°C as indication for paracetamol. Add paracetamol IV as an option.

Insert box "Pre-alert ED" after "could this be a severe infection?

Check pre-alert ED when SIRS Positive with Emergency Medicine Programme.

Remove red box on left "Take three blood cultures etc"

Risk Stratifier: delete Lactate > 2 mmol / L (venous)

Discuss with Vita Hamilton re meningitis suspected or > 45 min from ED (clarify when time starts calculating)

Following discussion delete reference to Cefotaxime 2 g IV, Ceftriaxone 2 g IV is the agreed antibiotic of choice.

4. ILCOR Guidelines

4.1 Draft updated CPGs

The following CPGs were presented for information outlining the proposed changes from ILCOR 2015 guidelines:

VF or Pulseless VT – Adult

Asystole – Adult

Pulseless Electrical Activity – Adult

Basic Life Support – Adult (practitioner)

Basic Life Support – Adult (responder)

Pre-hospital emergency childbirth

Post Resuscitation Care – Adult (P & AP)

Post Resuscitation Care – Adult (EMT)

Post Resuscitation Care (responder)

4.2 Heel compression

Brian Power presented a new concept of heel compression. This outlined the process whereby cardiac compressions can be performed by persons that cannot kneel down or have not got the strength in their arms to push the chest deep enough for effective compressions.

It was agreed that although heel compression probably worked, MAC could not recommend it at this stage as it was not evidence based or supported by ILCOR.

5. Standard Operations

5.1 Clinical lead handover

Change document title to: assuming clinical lead pre-hospital

When taking clinical lead change “I have clinical lead” to “I am assuming clinical lead”

When relinquishing clinical lead change “you have clinical lead” to “you are clinical lead”

Change “I have clinical lead” to “I am clinical lead”

Resolution: that the draft standard of operation "assuming clinical lead pre-hospital" be recommended to Council for approval.

Proposed: Conor Deasy **Seconded:** Derek Mooney

Carried without dissent

5.2 National pre-alert guidelines

Brian Power outlined that he had been in contact with Sean Walsh re the paediatric pre-alert conditions. Sean has advised that he has requested a new colleague, Michael Barrett, to look at this for MAC.

5.3 Response from HPRA

Brian Power referred to the reply from the HPRA in the meeting papers. The response in essence states that each licensed CPG provider may apply for the number of controlled medication units that it requires for operational requirements under two headings:

(a) Maximum quantity to be in position of paramedic/advanced paramedic

(b) Maximum quantity to be held on site

The HPRA reported verbally that provided the requested number of controlled medication units is reasonable there will be no difficulty.

6. Queries/Feedback from practitioners

6.1 Epinephrine infusion following cardiaogenic shock

Following discussion it was agreed that an Infusion pump is required for patient safety for Epinephrine infusion.

An alternative of 0.5 mL of 1:10,000 may be appropriate as a one off response to cardiogenic shock.

This will be explored further with the publication of the 2015 ILCOR guidelines.

6.2 GP issues with practitioners

As outlined in the meeting papers a GP has written to PHECC stating his concern about PHECC practitioners repeating vital signs and ECG outside a GPs surgery and in his opinion delaying the transportation to ED. A possible solution offered was for the practitioners to transcribe the last vital signs from the GP on to the PCR. During the discussion it was

highlighted that ED nurses are not permitted to accept vital signs from PHECC practitioners and record them on ED documentation, they must take them themselves and record them independently.

As a standard of care it was agreed that practitioners must take a set of vital signs on handover from GPs or other healthcare professional.

6.3 Pain management for ACS

Following discussion it was agreed that Paracetamol and Ibuprofen were not appropriate to manage cardiac chest pain.

6.4 Fluid temperature control

Following discussion it was deemed to be a service issue.

6.5 Treatment change suggestions – Epistaxis, Opioid OD & NR

(a) The inclusion of topical TXA for Epistaxis was rejected previously at MAC and the discussion led to the same conclusion.

(b) It was agreed that the Opiate overdose issue was a training issue.

(c) It was agreed that the neonatal resuscitation issue would be left until the 2015 ILCOR guidelines were published.

6.6 CPG Forum

The meeting papers had an e-mail from Niamh Cummins expressing concern about the CPG Forum and the activity levels in particular. It was suggested to write to the six members of the MAC CPG Forum and advise them to engage with Niamh Cummins, UL.

7. AOB

There was no AOB and the meeting concluded.

Next meeting Wednesday 25th & Thursday 26th November in The Killeshin Hotel, Portlaoise.

Signed: Niamh Collins Date: 23rd October 2015