Pre-Hospital Emergency Care Council

Medical Advisory Group Meeting

25th June 2015

In attendance	**Apologies**	**Present**
Niamh Collins	Mick Molloy	Brian Power
Derek Rooney	Mark Doyle	Deirdre Borland
Peter O'Connor	Shane Mooney	
David O'Connor	Ken O'Dwyer	
Dave Irwin	Conor Deasy	
Shane Knox	Cathal O'Donnell	
Declan Lonergan	Joe Mooney	
Jack Collins	David McManus	
Macartan Hughes	Séamus McAllister	
Martin O'Reilly	David Menzies	

1. **Chair's Business**

   The vice chair welcomed the members and apologies were noted; including those of the Chair. The committee were informed of the appointment of Mr Peter Dennehy to the position of Director of PHECC and he was wished well in his new role.

2. **Minutes and matters arising**

   Resolution: That the minutes of the Medical Advisory Committee Thursday 28th May be approved.

   Proposed: Shane Knox **Seconded:** David Hennelly
   Carried without dissent

   3.1.4 Feedback is still awaited as to the availability of suspension of Chlorphenamine, it currently is not in the 7th schedule, should suspension or IN be required this will need to be via interim directive. Jack Collins and Brian Power to research this further. PHECC will make every effort to expedite the inclusion of Chlorphenamine on the next edition of the 7th schedule.

3. **CPGs**

   3.1 CPG updates following prioritisation

   3.1.1 Draft CPG Anaphylaxis – Adult (4/5/6.4.15)
   Chlorphenamine will be the spelling used going forward, as there are two acceptable spellings.
   It was agreed to follow the RCPI 2014 recommendation and have a maximum of three doses of Epinephrine. It was also agreed that for patient's ≥ 100 Kg that 1 mg Epinephrine was the appropriate dose.
   Following discussion regarding the appropriateness of glucagon, salbutamol and atropine for patients on beta blockers who have not responded to Epinephrine it was decided not to implement these medications. It was agreed to introduce a pathway to the bradycardia CPG if bradycardia after Epinephrine.

To avoid any confusion the IV route for Hydrocortisone would be separated from the paramedic symbol.

3.1.2 Draft CPG Anaphylaxis – Paediatric (4/5/6.7.31)
Amendments as per the anaphylaxis adult CPG were agreed.

3.1.3 Draft CPG External Haemorrhage Adult (4/5/6.6.3)
A question was raised in relation to restricting scalp stapling for APs only. It was agreed to roll the skill out for APs initially. The wording be changed to 'temporary closure for haemorrhage control'
The equipment list to be removed from the CPG.

Resolution: That the medical advisory committee recommend the draft CPG External Haemorrhage - Adult CPG for the next phase of the development process.

Proposed: Peter O'Connor **Seconded:** Macartan Hughes
Carried without dissent

3.1.4 Draft CPG External Haemorrhage – Paediatric (4/5/6.7.50)
Amendments as per the External Haemorrhage – Adult CPG were agreed.

Resolution: That the medical advisory committee recommend draft CPG External Haemorrhage – Paediatric for the next phase of the development process.

Proposed: Derek Rooney **Seconded:** David Hennelly
Carried without dissent

3.1.5 Draft CPG Glycaemic Emergency – Adult (4/5/6.4.19)
An email from a practitioner was tabled relating to patients with blood sugar of < 4 mmol/L and not symptomatic. It was decided that this was a training issue and clinical judgement should be use.
No changes were recommended to the draft CPG.

Resolution: That the medical advisory committee recommend draft CPG Glycaemic Emergency – Adult for the next phase of the development process.

Proposed: Peter O'Connor **Seconded:** Declan Lonergan
Carried without dissent

3.1.6 Draft CPG Glycaemic Emergency – Adult (2/3.4.19)
No changes were recommended to the draft CPG.

Resolution: That the medical advisory committee recommend draft CPG Glycaemic Emergency – Adult for the next phase of the development process.

Proposed: Shane Knox **Seconded:** David Irwin
Carried without dissent

3.1.7 Pain Management – Adult (4/5/6.2.6)
It was suggested that the introduction of Ketamine be explored. Dr Katie Padfield who has extensive experience with this medication in the pre-hospital environment to be invited to speak to the committee. It was agreed to remove Tramadol from the CPG.

3.1.8 Pain Management – Paediatric (4/6.7.5)
The introduction of fentanyl lollipops was discussed. This will be further investigated. It was agreed to remove Tramadol from the CPG. It was agreed to include the IM route for Ondansetron.

3.1.9 Seizure/Convulsions – Adult (5/6.4.23)
A practitioner submitted a query in relation to a second episode of seizing during a long journey where the maximum dose (two) of Midazolam was administered. The practitioner requested that the second seizure episode be regarded as a new episode and Midazolam be administered. It was agreed that the primary focus should be to control the seizure as failure to control it could result in harm. Concern was raised about the possibility of respiratory depression following Midazolam, however it was agreed that practitioners were very competent on airway management and ventilation and that the primary focus should be to stop the seizing. Medical oversite was suggested, however this is not available to paramedics who would administer the Midazolam. It was agreed to remove the maximum dose for anticonvulsant medications and to insert 'repeat at 5 minute intervals prn'
It was reported that restrictions imposed by the Health Products Regulatory Authority (HPRA) licence limits supply to two doses of Midazolam. This causes difficulties on the ground in light of increased doses. PHECC will engage with the HPRA on this issue.

In light of the number of calls seeking medical oversight for increased doses, it was suggested that repeat be removed to repeat prn removing the max dose be removed on the CPG. The formulary should state 'repeat at 5 minute intervals'

3.1.10 Seizure/Convulsions – Paediatric (5/6.7.33)
Amendments as per the Seizure/Convulsion – Adult CPG were agreed.

3.1.11 CPG Actual/Potential Shock blood loss (trauma) – Adult (5/6.6.8)
It was agreed to remove advice box on log roll and pelvic splint. A trauma care appendix to be developed where key principles will be stated rather than on the CPG to guide education and training;

- Minimal patient handling
- Avoid clot disruption
- Apply pelvic splint where applicable
- Avoid log roll where possible.

Resolution: That the medical advisory committee recommend draft CPG Actual/Potential Shock blood loss (trauma) – Adult for the next phase of the development process.

Proposed: Peter O'Connor **Seconded:** Declan Lonergan
Carried without dissent

3.2 Draft Tachycardia – Adult (5/6.4.12) CPG for review.

No changes were recommended to the draft CPG.

Resolution: That the medical advisory committee recommend draft CPG Tachycardia – Adult for the next phase of the development process.

Proposed: Peter O'Connor **Seconded:** Derek Rooney
Carried without dissent

4. ILCOR Guidelines 2015

The draft ILCOR guidelines were included in the papers. The Chair congratulated Brian Power on his work on the previous ILCOR guidelines. Brian outlined that it took over a year to agree CPGs following the release of the 2010 ILCOR guidelines which is not acceptable. In order to expedite the development of CFR materials and CPGs initial discussion and early decision making was encouraged.

It was explained that the guidelines were draft until they were officially published in October 2015, however if MAC could give clear direction on support or otherwise for the draft guidelines work could commence on the changes.

There are six domains in the draft guidelines and each individual one has a 'Recommend' or 'Suggest' associated with it. The level of recommendations and level of evidence associated with each guideline are also graded. Draft guidelines that did not have a direct pre-hospital application were not presented or discussed.

PHECC to initiate draft changes to CPGs and other standards based on the MAC recommendations listed below. A final decision will be made when the 2015 ILCOR Guidelines are published.

Basic Live Support

BLS 1 Supported
BLS 2 Supported
BLS 3 Supported for (i) and (iv). (ii) and (iii) not supported
BLS 4 Supported
BLS 5 Supported
BLS 6 Supported – but only for second or subsequent person on scene
BLS 7 Supported – no change from current practice
BLS 8 Supported in principle – merits further investigation
BLS 9 Supported
BLS 10 Supported
BLS 11 Supported

Neonate

Neo 1 Supported
Neo 2 Not supported

Pre-Hospital Emergency Care Council

Neo 3 Not supported – recommendation that training should occur every year but absolutely must occur every two years

Neo 4 Not supported

Frist Aid

FA 1 Supported
FA 2 Not supported
FA 3 Supported – no change from current practice
FA 4 Not supported
FA 5 Not supported
FA 6 Supported
FA 7 Not supported
FA 8 Supported
FA 9 Not supported
FA 10 Not supported

Education and Training

E&T 1 Supported
E&T 2 Supported
E&T 3 Supported
E&T 4 Supported – no change from current practice
E&T 5 Not supported
E&T 6 Supported

Advanced Life Support

ALS 1 Supported – avoid hyperthermia
ALS 2 Supported
ALS 3 Supported
ALS 4 Supported – no change from current practice
ALS 5 Supported
ALS 6 Not Supported
ALS 7 Supported
ALS 8 Supported – no change from current practice
ALS 9 No decision – Final decision not made in draft recommendations.
ALS 10 Supported
ALS 11 Supported
ALS 12 Supported
ALS 13 Not supported

Paediatric

Paeds 1 Supported

5. Practitioner query on management of paediatric Stridor

It was agreed that nebulised Epinephrine was appropriate for croup and will be progressed in the CPG.

Pre-Hospital Emergency Care Council

6. AOB

6.1 Brian Power indicated that feedback is still outstanding from the obstetric programme regarding the emergency obstetrics CPGs. Brian will make contact again with the programme.

6.2 An email from Ken O'Dwyer regarding the Spinal injury management seminar was read to the group. He expressed a concern regarding the balance of the discussion. Brian Power reiterated that the seminar was only part of the deliberation process.

6.3 The chair congratulated Shane Knox on the award of his PhD.

6.4 The EMP pre-alert guideline was circulated to the group. It was suggested that a pre-alert standard be developed by PHECC. Sean Walsh to be consulted in relation to paediatric alerts.

6.5 It was highlighted that clear handover of clinical lead on scene is problematic. This can be particularly so when APs arrive on scene and they sometimes dance around the issue not wishing to cause offence or alienation. It was suggested that the aviation industry standards should be followed as there is clear precise wording whenever one pilot hands over flight command to another. Brian Power to come back with suggested wording that could be adopted throughout the pre-hospital environment to avoid any ambiguity.

Next meeting Thursday 24th September.

Signed: Niamh Collins

Date: 24th July 2015