

## Medical Advisory Committee

Meeting Minutes 26<sup>th</sup> May 2016

Osprey Hotel, Naas

### In attendance

Declan Lonergan  
Martin O'Reilly  
David Hennelly  
David Menzies  
Cathal O'Donnell  
Macartan Hughes  
Gerry Bury  
Eoghan Connolly  
Peter O'Connor  
David O'Connor  
Derek Rooney  
Michael Dineen

### Apologies

Mick Molloy  
Jack Collins  
Niamh Collins  
Joseph Mooney  
Shane Knox  
Seamus McAllister  
Ken O'Dwyer  
Shane Mooney

### Present

Brian Power PHECC  
Jacqueline Egan PHECC  
Margaret Bracken PHECC

### 1. Chair's Business

Mr Brian Power informed the members that the Chair, Dr Mick Molloy, and the Vice Chair, Dr Niamh Collins, were unable to attend the meeting and suggested that Ms Jacqueline Egan, PHECC Programme Development Officer, chair the meeting on this occasion which would permit maximum involvement from all the members present. There was general agreement with this recommendation.

**Resolution:** That Ms Jacqueline Egan chair the May 2016 MAC meeting.

**Proposed:** David Hennelly  
Carried without dissent

**Seconded:** David Menzies

All present at the meeting expressed their condolences to Mr Power on the recent passing of his Aunt.

### 2. Draft Meeting Report – 28<sup>th</sup> April 2016

The minutes of the meeting held on 28<sup>th</sup> April were reviewed.

**Resolution:** That the minutes of the Medical Advisory Committee 28<sup>th</sup> April be approved.

**Proposed:** Peter O'Connor  
Carried without dissent

**Seconded:** Michael Dineen

### 3. Pre-hospital spinal injury management standard

A draft PHECC standard for pre-hospital spinal injury management, with summary and recommendations for MAC, was included in the meeting papers. Comments and feedback from Dr Niamh Collins were tabled at the meeting for consideration.

There was robust discussion on each recommendation and amendments made as follows;

**'Active spinal motion restriction'** is defined as using manual inline techniques and/or spinal injury management devices to reduce spinal column motion.

**Change:**

- 'and/or' replaced with 'with or without'

Change 'No Risk' to 'Minimal Risk' throughout the document

#### Original Recommendation 2:

**Following trauma should any of the following factors be present;**

- age 65 years or older
- 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.

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

#### New 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**

**Original Recommendation 3:**

**Following trauma should any of the following factors be 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
- delayed onset of neck pain
- the person remains at low risk if they are:  
unable to actively rotate their neck 45 degrees to the left and right (the range of the neck can only be assessed safely if the person is at low risk and there are no high-risk factors)

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

**New 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**

**Original Recommendation 4:**

**Following trauma should any of the following factors be present;**

- have only one of the low-risk factors and
- are able to actively rotate their neck 45 degrees to the left and right

**the patient should be regarded as 'no risk' and not have spinal motion restriction applied**

**New 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**

**Original Recommendation 5:**

**Following a trauma assessment should a patient present with any of the following PHECC indicators for spinal injury;**

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

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

**New 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**

**INSERT NEW RECOMMENDATION**

**New Recommendation 6:**

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

Please note; as a result of inserting a new recommendation the numbering sequence from original to new will alter from here down.

**Original Recommendation 6, now 7:**

**Following trauma assessment should a patient not present with any of the PHECC indicators for spinal injury and are deemed at low risk; passive spinal motion restriction shall be implemented until arrival at ED**

**New 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.**

**Original Recommendation 7, now 8:**

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

- are deemed to have no risk factors
- do not present with any of the PHECC indicators for spinal injury
- are pain free and are able to actively rotate their neck 45 degrees left and right

**New 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

**Original Recommendation 8, now 9:**

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

**New 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.**

**ORIGINAL RECOMMENDATION 9 TO BE DELETED**

**Original Recommendation 10:**

**If mechanism of injury and clinical assessment suggest an isolated non cervical spine injury a cervical collar is not indicated.**

**New Recommendation 10:**

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

**Original Recommendation 11:**

**Patients with high or low risk factors and not presenting with any of the PHECC indicators for spinal injury may be requested to self-extricate from a vehicle and be instructed to lie down on a trolley stretcher in a position of comfort.**

**New 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.**

**Original Recommendation 12:**

**If a patient, with a suspected spinal injury, is ambulatory following trauma request the patient to lie down on the trolley stretcher and do not utilise a 'standing take down'.**

**New 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.**

**Original Recommendation 13:**

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

**New 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.**

Original Recommendation 14:

**A long board or a split device should not be used during transportation of a patient. It may be acceptable only if the patient has immediately life threatening injuries and the time to repackage the patient would be detrimental to the patient.**

New Recommendation 14:

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

Original Recommendation 15:

**The standard of care for the transport of a patient with active spinal motion restriction shall be on a vacuum mattress. It is acceptable to use other spinal injury management devices during transport if the patient has immediately life threatening injuries and the time to repackage the patient would be detrimental to the patient.**

New 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.**

Original Recommendation 16:

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

New 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.**

Original 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-proprietary methods such as rolled blankets may be utilised to accomplish spinal motion restriction.**

New 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.**

Original Recommendation 18:

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

New 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**

Original Recommendation 19:

**Paediatric patients following trauma should be assessed for spinal injury using the PHECC indications for spinal injury, however practitioners should err on the side of caution.**

New Recommendation 19:

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

Original Recommendation 20:

**Paediatric patients with suspected spinal injury should have spinal motion restriction applied using a vacuum mattress, however they should not be forced into this position. Manual spinal motion restriction should be provided if the child is distressed or uncooperative. Non-proprietary methods such as rolled blankets may be utilised to accomplish spinal motion restriction.**

New 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.**

**INSERT NEW RECOMMENDATION**

New Recommendation 21:

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

Original Recommendation 21, now 22:

**Very young paediatric patients with suspected spinal injury should have spinal motion restriction applied using the child's own car seat if it is intact following the trauma, however they should not be forced into this position. Manual spinal motion restriction should be provided if the child is distressed or uncooperative.**

New 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.**

Original Recommendation 22, now 23:

- (i) EMTs shall provide active spinal motion restriction for all patients with any PHECC indicators for spinal injury whether 'High Risk', 'Low Risk' or 'No Risk' factors are present.**
- (ii) EMTs shall provide active spinal motion restriction for all patients with no PHECC indicators for spinal injury and 'High Risk' or 'Low Risk' factors are present.**
- (iii) EMTs may consider no spinal motion restriction if no PHECC indicators for spinal injury and 'No Risk' factors are present.**

New 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.**

Original Recommendation 23:

**Recommendations 1, 2, 5, 7, 8, 11, 12, 13, 14, 15, 16, 17, 19, 20, 21 shall apply to EMTs when managing suspected spinal injury.**

New 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.**

**INSERT NEW RECOMMENDATION**

New 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.**

Original Recommendation 24, now 26:

**Responders at EMR and FAR/ OFA level should return head to neutral position (unless pain or resistance increases) and maintain spinal motion restriction if spinal injury is suspected.**

New 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.**

**INSERT NEW RECOMMENDATION**

New 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.**

Original Recommendation 25, now 28:

**Responders at EFR level, while maintaining spinal motion restriction, may apply a cervical collar to facilitate extraction.**

New 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 extraction.**

Original Recommendation 26, now 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;  
An unstable environment prohibits the attendance of a practitioner or  
While awaiting the arrival of a practitioner the patient requires rapid extrication to initiate emergency care**

New 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**

Original Recommendation 27, now 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 vacuum mattress.**

New 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.**

Original Recommendation 28, now 31:

**Responders at EFR level, who are operating on behalf of a licenced CPG provider shall not utilise a 'standing take down' if a patient, with a suspected spinal injury, is ambulatory following trauma. The patient shall be requested to lie down on the trolley stretcher or other device.**

New 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.**

**Original Recommendation 29, now 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 PCR and present the top copy to the practitioner transporting the patient to ED.**

**New 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.**

**INSERT NEW RECOMMENDATION**

**New 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.**

**4. CPG updates**

**4.1 Spinal injury management CPGs**

**5/6.6.9 Spinal Injury Management**

- Replace 'Trauma Initial indications for spinal injury' with 'Trauma and concern by practitioner of spinal injury'
- Concern was expressed about the use of 'Any PHECC indicators for spinal injury present'
- Replace 'No risk factors' with 'Minimal risk factors'
- As per policy all patients presenting with 'High risk factors' should have active spinal motion restriction applied until assessment is complete
- As per policy all patients presenting with 'Low risk factors' should have passive spinal motion restriction until assessment complete
- Under 'Minimal risk factors' retain the red box from the current CPG; 'Immobilisation may not be indicated'
- Edit grey box 'Vacuum mattress' to read 'Secure to appropriate transportation device'
- Update all red information boxes on right to correspond with changes to policy recommendations

**4.6.9 Spinal Injury Management**

- Changes as per CPG 5/6.6.9 and new policy recommendations

**2/3.6.9 Spinal Injury Management**

- Replace 'Trauma Initial indications for spinal injury' with 'Trauma and concern by responder of spinal injury'
- Changes as per CPG 5/6.6.9 and new policy recommendations

## 4.2 Palliative Care CPG

### 5/6.8.7 Palliative Care – Adult

At the last MAC meeting on 28<sup>th</sup> April some members expressed concerns that the palliative care CPG was signed off by Council without going through the Delphi process. Following a resolution from the meeting the palliative care CPG was put through a Delphi process. The results of the Delphi were included in the meeting papers.

Brian Power explained that the National Palliative Care Programme and the ICGP have been notified that Council had approved both the palliative care policy and the CPG. He also outlined that Dr Feargal Twomey, Consultant in Palliative Medicine, a member of the Palliative Care Sub Group had agreed to be involved in developing the training package.

There was a robust and detailed conversation among the members and issues identified. The members all agreed that this is a clinically excellent CPG and represents the way CPGs should be developed in the future. Concerns were raised about the services, structures and the education specific to this, which are currently not in place.

**Resolution:** that MAC has concerns about service delivery and educational requirements in relation to the introduction of the Palliative Care – Adult CPG. MAC recommends that the CPG be brought back to Council for further consideration.

**Proposed:** David Menzies  
Carried without dissent

**Seconded:** Cathal O'Donnell

## 4.3 Verification of Death CPG

### 5/6.8.x Verification of Death

The results of the Delphi for the Verification of Death CPG were included in the meeting papers. Brian Power informed the members that the Dr. Myra Cullinane, President of the Coroners Society of Ireland, and An Garda Síochána were consulted in relation to the policy. To date Dr Cullinane requested minor changes to the policy and PHECC is still awaiting final feedback from An Garda Síochána. The members expressed their support and welcomed this CPG as it will enable ambulance crews to leave the scene and not be tied up for several hours waiting for a doctor to pronounce death.

There was some concern that verification of death will not change anything as the patient still has to be pronounced by a medical practitioner. It was suggested that the CPG and policy be reviewed within one year of being enacted to progress to full pronouncement of death when experience following implementation will assist with this review.

**Resolution:** that CPG 5/6.8.x Verification of Death be recommended to Council for approval.

**Proposed:** Cathal O'Donnell  
Carried without dissent

**Seconded:** Peter O'Connor

#### 4.4 Sepsis – Paediatric CPG

##### 5/6.7.34 Septic Shock – Paediatric (≥ 15 years)

No changes recommended.

**Resolution:** that CPG 5/6.7.34 Septic Shock – Paediatric (≥ 15 years) be recommended to Council for approval.

**Proposed:** Peter O'Connor

**Seconded:** Michael Dineen

Carried without dissent

#### 5. Practitioner queries re CPGs and medications

An email to Brian Power with the following practitioner queries was included in the meeting papers for discussion.

##### 5.1 Definition of 'tolerable' pain

**Query:**

*"the omission in the care principals for pain, of a means of determining from the patient where practical what their goal is so we can then determine what constitutes tolerable".*

The practitioner's concern is that tolerable pain can be very different for everyone and the definition in the care principals is too vague. After significant discussion the general consensus was that pain is subjective, and pain free is not possible otherwise all patients would be administered medications from the top of the pain ladder i.e. morphine regardless of the severity of the pain. Brian Power explained that 'tolerable pain' was the term agreed at the previous MAC meeting.

##### 5.2 Hypoglycaemia as a reversible cause of cardiac arrest

**Query:**

*"the absence of hypoglycaemia on the reversible causes list for cardiac arrest, the consequent teaching in the NASC was not to check blood sugar due to this omission".*

It was clarified that hypoglycaemia is not a reversible cause of cardiac arrest. The general consensus among the members was that blood sugar should be checked post ROSC in particular and it is not necessary to list this on a CPG.

#### 6. PHECC CFR Information Standard 2016

A draft of the PHECC CFR Information Standard 2016 was handed out to each of the members present, and a differences table with the current 2011 edition was included in the meeting papers. Ms Jacqueline Egan, PHECC Programme Development Officer, gave an overview of the differences. Ms Egan explained that new CFR training materials are currently being developed and due to be in circulation shortly. The feedback from the members was very positive with a recommendation to include a box for 'time of onset'.

**Recommendation:** That the PHECC CFR Information Standard 2016 be recommended to Council for approval subject to the inclusion of a box for 'time of onset'.

**Proposed:** Derek Rooney

**Seconded:** Eoghan Connolly

Carried without dissent

**7. Suggested update for 'Difference of opinion by MAC members on areas of clinical importance' document**

The current PHECC Council's term of office and all committees will terminate in June. The final MAC meeting scheduled to take place on 8<sup>th</sup> June will focus on Terms of Reference, and it was agreed to postpone this document for the attention of the new Medical Advisory Committee, as the Terms of Reference might change in June.

**8. AOB**

As there was no other business the Chair thanked all present for their contribution to the meeting and the meeting concluded.

The next meeting of the Committee will be held on Wednesday 8<sup>th</sup> June 2016 in The Malton Hotel, Killarney.

Signature:



Date:

14<sup>th</sup> June 2016