



Apologies:

Gerry Kerr  
Rory Prevett  
Conor Deasy  
Cathal O'Donnell  
Derek Rooney  
Stephen Cusack  
Seamus McAllister  
Joe Mooney  
Declan Lonergan  
David Irwin  
Jack Collins  
Mark Doyle

Present:

Mick Molloy  
Peter O'Connor  
David Menzies  
Shane Knox  
Macartan Hughes  
Niamh Collins  
David Hennelly  
Martin O'Reilly  
*Shane Mooney*

In Attendance

Brian Power  
Deirdre Borland

## 1. Chairs Business

The Chair welcomed the assembled members and apologies were noted. Congratulations were extended to Joe Mooney on the commencement of his Paramedic training.

## 2. Draft Meeting Report - Thursday 26<sup>th</sup> March 2015

Niamh Collins asked that three edits were made to the minutes to better reflect the discussion around items 4 & 5. Edits were completed as requested prior to being signed.

**Resolution:** That the Medical Advisory Committee approve the minutes from the meeting of March 2015.

**Proposed:** Macartan Hughes

**Seconded:** David O'Connor

Carried without dissent.

### 2.1 Matters Arising

- 2.1.1 An opinion from clinical pharmacologist Prof Peter Weedle regarding the combination of Morphine and Fentanyl was presented in the meeting papers. His opinion; that "given the maximum dose of both Morphine and Fentanyl allowable for both adult and paediatric use, toxicity would seem highly improbable" was accepted by the committee.

### 3. CPGs

#### 3.1 CPG updates following prioritisation

##### 3.1.1 Actual/Potential Shock from blood loss (trauma) – Adult

A draft of the amended CPG was included in the meeting papers. It was suggested that pelvic splints be encouraged – this was deemed to be a training issue. Include a decision box with “signs of shock” before first fluid bolus.

Change phraseology from “load and go” to “prioritise transport”

It was suggested that a table of standardised pre arrival alerts be developed rather than included on individual CPGs. Niamh Collins committed to draft same. The changes will be made and returned to at a further meeting.

##### 3.1.2 Allergic Reaction /Anaphylaxis – Adult

A draft of the amended CPG was included in the meeting papers. It was agreed to combine all three clinical levels in one CPG. It was suggested that an “either/or” option be included allowing auto injector or ampule epinephrine.

It was suggested that IV is the best route for chlorophenamine administration and that this route should be available for available for APs for anaphylaxis. It was also suggested that the IN route for chlorophenamine administration be considered rather than IM. It was agreed that fluid administration should be started earlier, i.e. before the second epinephrine

It was suggested that in light of the committee highlighting that IV route being more effective for many medications, consideration be given to permitting paramedics to administer the IV route. This was determined to be an issue meriting dedicated discussion and was referred to a future meeting.

It was suggested that the CPG layout be amended to reflect that of the asthma CPG i.e. start with mild and progress to moderate and severe. In absentia Rory Prevett asked that consideration be given to including IM hydrocortisone (paramedic) on this CPG. This was agreed. The word asthma be changed to bronchospasm. The changes will be made and returned to a further meeting.

### 3.1.3 Allergic Reaction /Anaphylaxis – Paediatric

It was agreed that the changes in the adult CPG be reflected in the paediatric CPG.

### 3.1.4 Chlorphenenamine Medication Formulary

It was suggested that a suspension presentation may be more useful for paediatric administration. Brian Power to check 7<sup>th</sup> schedule. In keeping with the changes to the CPG, an IV route will be available for APs.

### 3.1.5 Pain Management - Adult

A draft of the amended CPG was included in the meeting papers. Methoxyflurane and IV Paracetamol will be included (under moderate and severe pain). Consideration will be given to the inclusion of Ketamine; however this will merit further discussion and debate. An IM route option for <sup>Odansetron</sup>~~Odansetron~~/Cyclizine was also agreed. The changes will be made and returned to a further meeting.

### 3.1.6 Pain Management - Paediatric

The changes in the adult pain management CPG will be reflected in the paediatric CPG. PR route is a valid alternative option for the administration of paracetamol and ibuprofen. The sensitivities around administration via PR route for paediatric patients was recognised, a policy statement of rationale and respect to the dignity of patients; particularly pre-teen and teenage girls will be developed. The Medication Formulary will be amended accordingly.

### 3.1.7 Methoxyflurane Medication Formulary

The Methoxyflurane medication formulary was agreed

### 3.1.8 Glycaemic Emergency- Adult (Practitioner)

A draft of the amended CPG was included in the meeting papers. The draft combines all practitioner levels. Following discussion the CPG changes as presented in the meeting papers were accepted.

### 3.1.9 Glycaemic Emergency – Adult (Responder)

Following discussion the CPG changes as presented in the meeting papers were accepted.

### 3.1.10 Glycaemic Emergency – Paediatric

The CPG combined all practitioner levels, it was agreed to change “prohibit the administration of glucagon to paediatric patients who have not had a diabetes diagnosis” from an advice to a red box. All other aspects of the CPG as presented in the meeting papers were agreed.

## 3.2 Tachycardia CPG review

A draft of the amended CPG was included in the meeting papers. It was suggested that the entry point be changed to non-sinus tachycardia. It was suggested to insert synchronised before cardioversion and delete “(sync on)”. For broad regular QRS complexes add “consider” amiodarone. Add an advice box “shock first if unresponsive” remove “double the energy” from advice box.

Caution was expressed that rather specifying the joules “escalate the energy” should be indicated. Caution was expressed rather than a reliance on calling for medical oversight, particularly in regard to APs working in rural locations as mobile phone network is not always reliable. Concerns were expressed regarding the administration of amiodarone to unstable patients. A lengthy debate ensued.

## 3.3 CPGs for prescription only medications for non-clinical persons.

The Chair indicated that the development of the Draft CPGs included in the meeting papers came about as a result of a request from the Dept. of Health. The Chair indicated that he did not feel it appropriate that the MAC develop this item without further details by way of a written request, from the Dept. of Health.

Brian Power informed the Committee that the Department was invited to come to the present the requirement at this meeting which was declined. The committee expressed its support to regularise these circumstances in an informed rather than a reactionary manner. A concern was raised about the minimal clinical level acceptable for non – medical persons administering medications. It was agreed that CFR or equivalent be a precursor to undergoing any such specialist training. The committee will await the Department’s further engagement.

#### 4. Standards of Operations

##### 4.1 Report from subgroup meetings;

###### 4.1.1 Local Injury Sub group

Minutes of the inaugural local injury subgroup were included in the meeting papers. The agreed principles as outlined in the meeting papers of the LIU inaugural meeting were discussed. These principles were agreed.

###### 4.1.2 Clinical care at events sub

Minutes of the inaugural clinical care at events subgroup were included in the meeting papers. It was agreed that membership be extended by inviting a representative, clinical practitioners only, from organisations providing care at events as recommended in the meeting minutes.

#### 5. AP query on Midazolam

A query from an advanced paramedic was submitted to the group regarding a seizing patient and the timing or administration of second dose buccolam midazolam. It was pointed out that only two doses are permitted to be carried in vehicles. There is however two doses at varying concentrations. This is a potential issue for those with long transport times.

It was suggested that this CPG should be amended to include the option of further doses, including considering timeframe between doses and be brought back to the committee.

#### 6. Draft resolution process for difference of opinion by MAC members on areas of clinical importance.

The consequences of agenda items being held up due to differences of opinions was discussed. A potential resolution process was included in the meeting papers. It was agreed that at least one of the clinical members from Council be a PHECC practitioner on the clinical decision panel.

**Resolution:** That the committee agree the resolution process as outlined in the meeting papers, subject to the agreed amendment.

**Proposed:** Mick Dineen                      **Seconded:** David O Connor.

Carried without dissent

**7. A.O.B.**

It was asked that that consideration be given to the inclusion of IV Paracetamol in the Sepsis CPG. Dr Vita Hamilton from the sepsis group has been engaged with this will be revisited at a future meeting.

A query was raised as regards which presentation of Nifedipine was appropriate to stock on the vehicles (standard or rapid release). The obstetric programme will be engaged with and this will be revisited at a future meeting.

Next meeting will be on the 25<sup>th</sup> June.

Signed: Niamh Collins

Date: 25.6.2015