The Medical Advisory Group

Meeting Minutes June 27th 2013

PHECC Office, Naas, Co. Kildare

Present		**Apologies**
Mick Molloy (Chair)	David O'Connor	Seamus Clarke
Niamh Collins	Ken O'Dwyer	David McManus
Macartan Hughes	Jack Collins	Stephen Cusack
Sean Walsh	Rory Prevett	Seamus McAllister
Gerry Kerr	Shane Knox	Derek Rooney
Martin O'Reilly	Joseph Mooney	Valerie Small
Gerry Bury	Mick Dineen	Neil Reddy
Declan Lonergan	Peter O'Connor	**In Attendance**
Mark Doyle	David Hennelly	Geoff King (Director)
David Menzies	Shane Mooney	Brian Power
Cathal O'Donnell		Anne Keogh
Dave Irwin		

1. Chair's business

The Chair welcomed the assembled members to the meeting and acknowledged apologies from absent members.

2. Minutes

Sean Walsh stated that he may have been mis-quoted and would like 4.1 in the minutes changed to reflect that he was happy for 'IN Fentanyl may be followed with Morphine if pain management was still an issue for longer journeys'.

Declan Lonergan raised an issue with point 4.2 in the minutes stating that some of the discussion around cooling following ROSC was not included. The minutes to include "a discussion ensued on the application of current practice on therapeutic hypothermia pre-hospital following ROSC".

Resolution: That the minutes from the Medical Advisory Committee meeting held on the 5th June 2013 be agreed subject to the changes outlined above.

Proposed: Ken O'Dwyer **Seconded:** Niamh Collins

Carried without dissent

3. Matters Arising

David O'Connor raised an issue with point 4.1 in the minutes asking if the Medication formulary could be changed to reflect the agreed position on Fentanyl and Morphine for pain management. Niamh Collins expressed that it include "must not exceed 2 or 3 doses".

Brian Power advised the committee that he had been in contact with Dr Diarmuid Smith from the HSE Diabetic Programme in relation to the treat and referral study and in particular treat and

referral following IV Dextrose. It was outlined to Dr Smith how treatment modalities i.e. IV Dextrose, Glucagon and Glucose Gel will be compared during the study. Brian Power read Dr Smith's response to the meeting. "I would encourage you to proceed with your research. Your research may help to guide us in the future in how best to manage patients. Hopefully your research will help the management of this important clinical decision".

The reply from Prof Kieran Daly, Clinical Lead National ACS programme, was tabled at the meeting. Following discussion on its content it was agreed to accept their recommendations.

Resolution: That the Medical Advisory Committee update the ACS CPG to reflect the changes recommended by the ACS Programme and recommend to Council the agreed changes.

Proposed: Gerry Bury **Seconded:** Martin O'Reilly

Carried without dissent

3. CPGs

3.1 Symptomatic Bradycardia – Paediatric

Council returned the Symptomatic Bradycardia – Paediatric CPG with a query in relation to commencing CPR on patients up to 14 years old. Sean Walsh stated that it is not age that is the question but inadequate perfusion. The process in ORHC is to commence CPR if the patient has a pulse rate <60 and inadequate perfusion. A member of Council had suggested that 'unresponsive' would be more definitive than altered level of consciousness. Niamh Collins stated that we should not wait until unresponsive. David Menzies stated if the child is conscious do not commence CPR. Mark Doyle asked the question is there anything in the guidelines CPR based on low heart rate in Children and Adults. Brian Power to check. Sean Walsh stated the APLS Manual revised in 2005 is a reference guide, he will forward reference chapter to Brian Power. David Irwin stated the ILCOR guidelines have no age. Sean Walsh requested that "inadequate perfusion" be the main criteria for CPR commencement.

On this CPG Gerry Bury raised the issue of 'consider advanced airway management' and stated that it may lead to confusion as it does not define the age profile. Brian Power stated that there is a CPG for advanced airway management for Paramedic which authorises supraglottic airway insertion in patients over 8 years old. Gerry Bury stated if over 8 and reference consistently. Niamh Collins suggested change to 'go to Advanced Airway CPG'. Gerry Bury suggested taking out the Consider advanced airways box, this was agreed by Mark Doyle. Geoff King noted that HSE are now recognising the Paediatric age as up to 16 years. The Chair asked could this be re-visited at the next meeting after all references have been submitted to Brian Power including ERC, APLS and CPR Clinical. The Chair stated that Brian Power will come back to the group with information.

3.2 ROSC CPG

Post-Resuscitation Care- Adult.

Brian Power stated changes were made. A document that had been submitted by Niamh Collins was tabled. Niamh Collins explained that this document was created by her for use in a hospital setting. She suggested that it could be adapted for use in the pre-hospital setting. It was noted that a bundle of care is more beneficial that single interventions. She suggested that a reference be made to O_2 and to titrate down. Gerry Bury stated that the CPG in relation to Amiodarone administration post ROSC required more clear direction. The statement 'persistent tachycardia for several minutes post ROSC' was of concern. It was agreed that this be changed to 'ventricular tachycardia for 3 to 5 minutes post ROSC' . Gerry Bury noted that there are training issues and there needs to be informed clinical decisions made, training is the underpinning of knowledge. Brian Power noted that the CPGs are not a training manual.

Gerry Bury also raised the concern about commending cooling and it not being continued in hospital. Brian Power suggested cooling pre-hospital only commences the process. Much discussion followed about cooling. Niamh Collins noted a Swedish expert's opinion on cooling. The issue of continuing cooling on arrival at the Emergency Department was discussed. Cathal O'Donnell stated some clinicians were not embracing cooling and that there is uneven practice in Emergency Departments across the country. Gerry Bury stated that there was limited evidence and the possibility of legal risk for both the Ambulance Service and PHECC. Geoff King requested that the issue of continued cooling be pursued nationally before pulling it apart. Brian Power advised the committee that he had not heard back from Dr Una Geary in relation to cooling following ROSC. It was suggested that contact be made with Dr Conor Deacy on the issue as he has conducted studies on this matter. The Critical Care Programme should also be contacted as it is ultimately an ICU issue on the management of therapeutic hypothermia. Gerry Bury also suggested that the Corcoran Review group should be consulted. It was agreed to await communication from the Emergency Medicine Programme prior to any decision on the issue. The Chair advised that 'active' be removed from the CPG and 'avoid hyperthermia' be included. Gerry Kerr suggested that the information box with detail of active cooling process be removed. It was agreed that this be removed.

It was also suggested that a 12 lead ECG be placed higher on the CPG than cooling.

3.3 Inadequate Respirations – review sub group

Gerry Bury stated that the subgroup had not reached conclusions on their deliberations. The subgroup are meeting again later that day. He stated that very useful discussion took place on key CPGs. 1. On presentation of materials and options available and 2. Content. Views will be presented back to MAC. Much discussion took place on the CPP's and CPG's used in the Queensland Ambulance Service. Geoff King stated he would liaise with Medical Director of the Queensland Ambulance Service about collaboration regarding CPP's and CPG's. The Chair advised that this be re-visited at the next meeting.

4. Queries re CPGs and medications

4.1 Proposed inclusion of LT Tube on the EMT Skills Matrix

Cathal O'Donnell informed the committee of the National Ambulance plan to standardise LT tubes as the supraglottic airway of choice for all practitioners including EMTs in the HSE National Ambulance Service. As EMT's will be dispatched to Echo calls it was appropriate that the advanced airway device was standard throughout. A concern was raised about all EMTs using a cuffed supraglottic tube as their use was more complex than an uncuffed tube. Brian Power suggested that a 'Special Authorisation' be included on the CPG which will enable EMTs to use cuffed supraglottic airways subject to appropriate training and Medical Directors sign off.

Resolution: That the Medical Advisory Committee recommends to Council that a special authorisation be included on the Advanced Airway – Adult CPG (4.3.1) to permit EMTs to use cuffed supraglottic airways subject to appropriate training and Medical Directors sign off.

Proposed: Mick Dineen **Seconded:** David Menzie

Carried without dissent

5. KPI - update

Mark Doyle informed the committee that a Consensus Conference is scheduled for the 4th of October to be held in the Naas area. Approximately 50-100 people will be in attendance.

6. Defibrillator Bill

The Public Health (Availability of Defibrillators) Bill 2013 is currently progressing through the Oireachtas. Discussion ensued about the Good Samaritan law and no legal duty or care. The issue of defibrillator being locked up in premises with no currently trained responder to operate them was discussed at length. Their usefulness in such a scenario was questioned. The following comments/ feedback emerged from the MAC discussion.

1. The terminology 'automated external defibrillator' and 'semi-automated defibrillator' should be changed to 'Advisory External Defibrillator' as there are no automated defibrillators in Ireland and they can be potentially dangerous.
2. It was felt that a 'sports club' in the list of designated places had no clear definition i.e. a golf society although technically a sports club does not necessarily have a premises in which an AED may be located.
3. Similarly premises with an attendance of 100 per day would be very small numbers to justify locating an AED.
4. It does not take into account that premises such as a sports stadium could be vacant most of the time and when occupied for an event pre-hospital emergency care providers will be in attendance with AEDs.
5. Geoff King gave the committee some background on the National Defibrillator Register currently being conducted by Gearoid Oman. He suggested that it may be more appropriate to register people rather than machines.
6. Approximately two thirds of arrests happened in the home therefore this bill will not have the impact that it possibly is anticipating on cardiac arrest saves.
7. It was noted that First Responders co-ordinated with the Ambulance Service such as in County Wicklow achieve better results than AEDs located at specified points.

8. It was recommended that the OCHAR data be used should a submission be made in relation to the Bill.
9. A major concern emanating from the committee is the potential for the negative effect from this bill from business and sports authorities as it would be seen as costly and bureaucratic with minimum actual use of the AEDs ever occurring.
10. Communities have a willingness to look after their own. The Bill could have the effect to drive volunteers away as the experience is that once something becomes compulsory or enforced volunteers drift off and commercial interests will emerge. This Bill it is felt will exclude communities.

The Chair requested that Council be informed of these views.

7. AOB

An email from Joseph Mooney, committee member, was tabled for discussion. It relates to EMT queries which contained four points to be addressed by the committee.

1. Query relating to head injury CPG. Is the practitioner meant to remove a patient from a long board and place him into a vacuum mattress? Brian Power pointed out that this was 'consider vacuum mattress' and not a directive. It was pointed out that for short journeys this was not required, however the practitioner should be cognisant of the duration the patient is on the long board.

2. Query relating to the treatment of epistaxis. Is there a requirement to transport a patient following successful treatment of an epistaxis episode? All practitioner CPGs currently end in transportation of patients, except for the new treat and referral CPGs which have not been released yet. Should a patient present at an event it is the responsibility of the Medical Officer of the event, or by extension of the CPG approved pre-hospital emergency care service provider for small events without medical cover, to have a clear policy in place in relation to treat and referral/discharge. Following a 999 call all patients currently are transported unless they decline. Discussion followed in relation to clinical care treatment at events.

3. Query relating to treatment of nausea /vomiting for EMTs. Should EMTs be authorised to administer anti-nausea / vomiting medication? David Irwin stated that currently Paramedics cannot administer anti-nausea medications. The question of transport time and what benefit patient would get from an anti-nausea treatment was discussed. Brian Power stated that Cylicine is on the 7th Schedule for paramedics and EMTs should MAC wish to extend its use to these clinical levels. Niamh Collins stated that on interfacility transports the transferring facility should treat for nausea before transport. Gerry Bury expressed concern about the side effects from anti emetics. It was agreed that it is not appropriate to extend this care level to paramedics or EMTs at this time.

4. Query relating 12 lead ECG use for EMTs. Currently 12 lead ECG is outside the scope of practice of EMTs. Macartan Hughes stated there would be little benefit in carrying out training which could not be used in the near future. It was agreed that it is not appropriate to extend this care level to EMTs at this time.

The HSE National Ambulance Service currently use Epistatus® (buccal Midazolam) as a management of seizures by advanced paramedics. As part of the introduction of buccal Midazolam for paramedic

use it was identified that Buccolam® a new product on the market was licenced and the Irish Medicines Board could not stand over the continued use of Epistatus® which is un-licenced. Buccolam® however is only licenced for patients between 3 months and less than 18 years old. The Irish Medicines Board states that if a licenced product is available and the service choose not to use it and use another product the Medical Director is personally responsible for adverse effects. An e-mail from Cathal O'Donnell outlining the issue and a paper identifying the impact of introducing Buccolam® were tabled at the meeting. Cathal O'Donnell informed the committee that the HSE NAS were planning on introducing Buccolam® (buccal Midazolam) in age specific pre-loaded syringes. The pre-loaded syringes were demonstrated to the committee. Based on the current dose, 0.5 mg/Kg these pre-loaded syringes would be under dosing for most of the age groups up to 9 years. Sean Walsh pointed out that OLHC dose is 0.3 mg/Kg for buccal Midazalom. Sean Walsh to send OLHC formulary to Brian Power. Details to be presented at the next MAC meeting for decision.

David Hennelly asked about introduction of Tranexamic Acid as a treatment for haemorrhage. Brian Power informed the committee it had been included in the draft for change to the 7th schedule and when updated then it will be introduced onto the haemorrhage CPG. Geoff King informated the committee that a new Chief Pharamisist has been appointed, however with the European Presediency committements a formal meeting to arrange changes to the 7th schedule will not be available until after the end of June this year.

The Chair thanked the group for their contribution to the meeting**.** September 26th was selected as the date for the next meeting.

Signed: _____ Date:_____