The Medical Advisory Group

Meeting Minutes June 5th 2013

PHECC Office, Naas, Co. Kildare

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

1. Chair's business

The Chair welcomed the assembled members to the meeting, in particular new members to the Medical Advisory Committee (MAC) and acknowledged apologies from absent members.

Brian Power gave a brief presentation on the workings of the MAC concentrating on the development process of new and updated CPGs.

The Director informed the group that the University of Limerick Centre for Prehospital Research (C.P.R.) have been commissioned to carry out an examination of the evidence base and practitioner experience base of our CPGs. C.P.R. have been extended an invitation to present their proposed methods of conducting the research to the next MAC meeting.

Mark Doyle queried the effect of the National Clinical Effectiveness Committee (NCEC) on the work of MAC. The Director confirmed that both PHECC and the Mental Health Commission are exempt from the NCEC requirements.

2. Minutes

Dr. Diarmuid Smith (via email) from the HSE Diabetic Programme supplied the following information in relation to a query regarding the treat and referral of patients who have been treated with Glucagon during a hypoglycaemic episode.

1. People who remain drowsy after injection of glucagon or who are on their own with no secondary carer should be brought to ED.

2. People who have recovered and have a carer/partner/spouse with them do not necessarily need to be brought to ED but should be asked to contact their diabetes centre or GP as soon as possible.

Sean Walsh asked that more specific clarity be sought in relation to IV Dextrose. It was agreed to contact the HSE Diabetes Programme with regard to this.

Brian Power also informed that group that thus far there has been no response from the Obstetric Programme regarding queries submitted on behalf of the previous MAG.

Resolution: That the minutes from the Medical Advisory Group meeting held on the 29th November 2012 be agreed subject to the changes outlined above.

Proposed: Gerry Bury **Seconded:** Cathal O'Donnell

Carried without dissent

3. CPGs

3.1 Treat & Referral

Mark Doyle questioned the temp of 38°C as a normal temperature in the Clinical Care Pathway decision CPG for Treat and Refer. He asked that this be changed to 36°C to 37.5°C

A Response from the HSE Epilepsy Programme regarding Treat and Refer – Isolated Seizure was included in the meeting papers. They gave preliminary endorsement for the guidelines with the following caveats:

1. They do not fulfil the criteria of the National Clinical Effectiveness Committee

2. They wish to see some tracking and audit information which will advise on adverse outcomes over the next 12 to 18 months.

The Director said that he would communicate with the NEP to advise them that all MAC decisions are put before Council for ratification where consumer interests are represented. He also said that he would reassure them that a research study would track all patients.

The response from the Diabetes Programme in relation to Glucagon was read to the meeting as it arrived too late for the meeting papers. Sean Walsh requested that similar advice be obtained in relation to IV dextrose and an endorsement from the Diabetes programme for Treat and Refer following IV Dextrose use.

Resolution: That the Medical Advisory Committee recommends to Council the following CPGs subject to agreed changes and endorsement.

- CPG 5/6.9.1 Clinical Care Pathway – Treat & Referral
- CPG 5/6.9.2 Hypoglycaemia – Treat & Referral.
- CPG 5/6.9.3 Isolated Seizure – Treat &Referral

Proposed: Niamh Collins **Seconded:** Cathal O'Donnell

Carried without dissent

3.2 ACS CPG update

- ACS advisory forum meeting report

A report from the national Acute Coronary Syndrome Programme was included in the meeting papers. Included was a request that Ticagrelor replace Clopidogrel for STEMI. The Director asked the committee to keep in mind that any new medications will place a training requirement of services and not result in an immediate change; there would also be a requirement to evoke interim directives until such time as the medication could be entered onto the 7th Schedule.

Seamus Clarke raised concerns regarding patients who may have been administered Clopidogrel by a GP and then transported by an AP who may administer Ticagrelor. He asked that any such change be communicated with the ICGP. It was agreed also to refer this matter to the ACS Programme for clarification.

Mark Doyle expressed his concerns of how the ACS Programme communicates such requests and asked that an official communication with PHECC rather than meeting minutes be submitted.

The Director committed to write to Kieran Daly for clarification.

Acute Coronary Syndrome CPG Changes.

The ACS CPG was included in the papers for review.

Cathal O'Donnell asked that the helicopter box be removed from the CPG. He also indicated that despite investing heavily in training and medications, no pre-hospital thrombolysis has occurred in some time and this will need further consideration.

David O'Connor asked for clarity within the PCI centres as patients with possible left bundle block and difficulty diagnosing MI. It was suggested that "discuss with PPCI Staff" be changed to "Discuss with PPCI Physician"

3.3 Inadequate Respirations – Adult 5/6.3.2

Brian Power presented the Inadequate Respiration CPG which MAC has requested updating. Niamh Collins expressed a preference for the previous version, she also questioned why bronchospasm is coming under an airway problem rather than breathing. Sean Walsh asked that the differentiation be made between respiratory distress and respiratory failure.

Brian Power agreed to bring back the original CPGs for the committee's information at the next meeting.

3.4 Inadequate Respirations – Adult – (4.3.2) & (3.3.2)

Sean Walsh questioned the inclusion of "max 10 per minute" for ventilations. Neil Reddy suggested "aim for" as a better turn of phrase. Macartan Hughes said that the EMT skills matrix does not include measurement of PEF so this should be removed. It was agreed to exclude aspects of indications for the various severity levels of asthma that were not within their scope of practice. It was also stated that for responder levels in particular that such items should be in "plain english". It

should also be stated that if moderate, severe, or life threatening call ALS. The addition of "consider" prior to positive pressure ventilations be included.

Gerry Bury questioned if the current system of reviewing these CPGs was the most efficient. He suggested that if review subgroups meet to view CPGs initially it may aid the group to focus on the higher level issues.

It was agreed that Gerry Bury, Niamh Collins, Sean Walsh, Jack Collins, Ken O'Dwyer and Joseph Mooney form a trial subgroup to review a set of CPGs on inadequate respirations working with Brian Power.

3.5 Poisons – Adult 6.4.23

An updated poison CPG was included in the papers for the committee's review.

Sean Walsh questioned the inclusion of cyanide, as he felt it may distract from more likely forms of poisoning such as carbon monoxide. The question arose as to whether or not this CPG was required.

Niamh Collins asked that the group consider specifying IN administration of midazolam in the case of poisoning due to psychostimulant use to avoid approaching a potentially unstable patient with a sharp. The Chair suggested the IN Naloxone can be followed by IM administration. Gerry Bury asked that the importance of reversing apnea not be lost.

Discussion ensued regarding the 10 mg max dose of Naloxone. It was agreed to leave it at 2 mg. It was also agreed that the IN dose for Naloxone is 0.8 mg

3.5.1 Poisons – Adult - 4/5.4.23

Brian Power outlined the only difference was the administration of Naloxone at EMT level. A discussion ensued on the appropriateness of adding Naloxone to the EMT medication matrix. Following assurance that it would be accommodated in the training standards the committee agreed. The dose of IN Naloxone to be increased to 0.8 mg

Resolution: That the Medical Advisory Committee recommends to Council the CPG Poison Adult 4/5.4.23 subject to agreed changes.

Proposed: Michael Dineen **Seconded:** Rory Prevett

Carried without dissent

3.5.2 Poisons – Adult 2/3.4.23

The Naloxone dose for IN to be increased to 0.8 mg. Gerry Bury outlined the Naloxone Programme for Drug workers being developed by UCD.

It was pointed out that Naloxone is a prescription only medicine and it may take some effort with the Department of Health to enable non registered people to be permitted to administer it.

The Director outlined that PHECC would engage with the Chief Pharmacist in the DoH on the matter, however due to the European Presidency it would be at least July before a meeting would occur.

The Director informed the committee that there may be a benefit of certain trained personnel such as community drug workers being able to administer naloxone in specific cases of opiate poisoning. It was agreed that this CPG be used for a test case subject to special authorisation

Resolution: That the Medical Advisory Committee recommends to Council the CPG Poison Adult 2/3.4.23 subject to agreed changes and authorisation of Naloxone for responders.

Proposed: Valerie Small Seconded: Niamh Collins

Carried without dissent

3.6 Hypothermia 5/6.4.24

When the Hypothermia CPG was being reviewed a question was raised as to whether to follow AHA or ERC guidelines on hypothermia temperature for mild, moderate and severe. The majority present expressed a preference for AHA. It was suggested that ≤35.9^{o}C should be used as upper limit for hypothermia. It was agreed to change mild to 35.9^{o}C -34^{o}C and moderate to 33.9^{o}C -30^{o}C.

Resolution: That the Medical Advisory Committee recommends to Council the CPG 5/6.4.24 Hypothermia subject to agreed changes.

Proposed: Mark Doyle **Seconded:** Peter O'Connor

Carried without dissent

3.7 Symptomatic Bradycardia – Paediatric

Brian Power advised that a practitioner pointed out the anomaly of tachycardia being included as signs of poor perfusion in the Symptomatic Bradycardia Paediatric CPG. It was agreed that tachycardia be removed from the CPG as it could be misleading and that it is reinforced that the list of signs of inadequate perfusion include the word "collective".

Resolution: That the Medical Advisory Committee recommend to Council CPG 4/5/6.4.9 Symptomatic Bradycardia – Paediatric, subject to agreed changes

Proposed: Jack Collins Seconded: Valerie Small

Carried without dissent

4. Queries re CPGs and medications

4.1 Query regarding fentanyl used in combination with other analgesia

A letter from an advanced paramedic seeking clarification on repeat administrations of IN fentanyl and using it in combination with other analgesics was included in the meeting papers. Sean Walsh confirmed that the initial dose of IN fentanyl would offer sufficient pain relief to allow the

practitioner to carry out interventions such as dressing or splinting. He also reiterated that there was no issue with following up IN fentanyl with PO or IV morphine.

4.2 Administration of Amiodarone following ROSC

Cathal O'Donnell outlined a number of instances where Amiodarone was administered while contrary to the CPG with positive outcomes. He asked that the group reconsider revising the CPG to include Amiodarone administration, adding a "does not exceed max dose" caveat and remove the reference to VF.

Niamh Collins suggested that the Practitioner should be permitted to administer Amiodarone even it had not been given in the instance of a cardiac arrest, ideally 300 mg over 1 hr or 150 mg over 10 mins up to a maximum of 450 mg.

It was agreed that if an un-stable V Tachy persisted for several minutes post ROSC or developed post ROSC then an Amiodarone infusion should be commenced, regardless if Amiodarone was administered during the arrest or not.

The infusion is a one off 150 mg in 100 mL over 10 minutes. The medication formulary for Amiodarone will require updating to reflect this also.

Gerry Bury asked that caution be used when exercising prehospital cooling. Martin O'Reilly agreed that there was a risk in starting cooling if the receiving hospital did not have a policy of active cooling. This CPG will be updated and returned to the next MAC meeting for consideration.

5. Draft Ticagrelor formulary

A draft entry to the medication formulary for Ticagrelor was included in the papers for the committees review. Seamus Clarke asked that the contraindications be checked by a pharmacologist.

Resolution: That the Medical Advisory Committee recommends to Council the Ticagrelor Medication Formulary subject to agreed pharmacological review.

Proposed: Cathal O'Donnell **Seconded:** Mark Doyle

Carried without dissent

6. Pronouncement of death by paramedics and advanced paramedics

Brian Power introduced a policy for the verification of expected death by HSE senior nursing staff. The Director outlined his engagements with the Dublin Coroner to date. It is hoped that PHECC can introduce a pronunciation of death policy for Paramedics and Advanced Paramedics in conjunction with the Coroner. The group will be informed of developments as they occur.

7. IAEM Guidelines Analgesia in the ED

Guidelines for Emergency Department analgesia developed by the Irish Association of Emergency Medicine were included in the meeting papers for the committee's information.

8. Emergency Department Mental Health Transport Guide

Mark Doyle gave a brief background to the guide. Macartan Hughes questioned the requirement for an emergency ambulance, in particular why an emergency ambulance is required for a voluntary admission. Brian Power questioned the need for the CEN categories. Seamus Clarke expressed a concern that Paramedics be expected to transport a patient whom the admissions team have deemed to be of too high a risk for their services. Mark Doyle stressed that the purpose of the guide was to ensure that patients requiring treatment for a mental illness be treated on par with those suffering a physical ailment.

It was agreed that the requirement for an emergency ambulance for any level was not appropriate; however, for an emergency transfer it could be considered. PHECC will communicate these findings back to the EMP.

9. Resuscitation Room Infusion guidelines

Resuscitation Room Infusion guidelines were included in the meeting papers for the committee's information.

10. Paramedics Australasia – Paramedicine Role Descriptions

A guide to Paramedicine Role Descriptions by Paramedics Australasia was included in the papers for the committee's information.

11. A.O.B

The Chair thanked the group for their contribution to the meeting**.** June 27th was selected as the date for the next meeting.

Signed: _____ Date:_____