

The minutes of the Medical Advisory Committee 26/03/2015

Present	Apologies	In attendance
Martin O'Reilly	Mick Molloy	Brian Power
Declan Lonergan	Seamus McAllister	Pauline Dempsey
Peter O'Connor	Sean Walsh	Deirdre Borland
David O'Connor	David Hennelly	
Shane Mooney	Mick Dineen	
David Menzies	Conor Deasy	
Shane Knox	Derek Rooney	
Niamh Collins	Gerry Bury	
Rory Prevett	Jack Collins	
Joe Rooney	Cathal O'Donnell	
Macartan Hughes	Valerie Small	
	David Irwin	

1. Chairs Business

The Vice Chair welcomed assembled members and apologies were noted.

2. Meeting Report – Thursday 29th January

Niamh Collins asked the minutes in relation to LIUs be amended to read that 'as ED resources are allocated to ED avoidance programmes'.

Resolution: That the meeting minutes of January 29th be approved subject to the inclusion the amendments listed.

Proposed: Joe Mooney

Seconded: David O'Connor

Matters arising:

The meeting was informed that the executive had advised Dr Skuce of PHECC's position relating to Capacity to Refuse Care.

Following a meeting with the Emergency Medicine Programme regarding the transport of patients to Local Injury Units, it was suggested that a Standard of Operations rather than a CPG may be more appropriate. It was also stated that there may be a need to follow local protocol with individual LIUs.

The subgroup will liaise with NAS as stakeholders through the development of this project. Niamh Collins asked that all stakeholders be included in the consultation process.

The palliative care subgroup have suggested that a GP must be contacted in order to prevent the unnecessary tasking of Gardaí to the home of an expected death.

The Dublin City Coroner has agreed to bring the verification of death process to his colleagues throughout the country and the Gardaí will also be informed of any developments.

3. 3. CPGs

3.1 CPG Prioritisation Criteria

The meeting was advised of a typo in the Tranexamic Acid priority schedule in the meeting papers (Pain/distress/anxiety very severe: should be 'x 2' and not 'x 5'). The corrected version was tabled at the meeting prior to the discussion. The vice chair introduced the replies from the prioritisation schedule and stressed her disappointment at the poor response rates. A discussion ensued regarding how to improve engagement from MAC members. It was suggested that members may not engage if they are not sufficiently familiar with the topic. It was agreed that the timeframe for respondents would be extended to one month and also that the question would be included on the top of the report. C.P.R. should be given a timeframe for critical appraisal feedback.

3.1.1 Tranexamic Acid

As Tranexamic Acid had a level (iii) priority it was designated to be addressed immediately the relevant CPG was included in the papers for deliberation. David Menzies gave a brief introduction his request to extend the indications for the administration of Tranexamic Acid. He suggested amending the entry point of the CPG to allow those who are not yet displaying symptoms of shock but with a significant mechanism of injury should be considered for Tranexamic Acid administration. He indicated that in St Vincent's University Hospital that traumatic haemorrhage that has a potential to develop into shock is an adequate rationale for administration of Tranexamic Acid.

3.1.2 Shock from Blood Loss (trauma) – Adult CPG.

The initial discussion suggested that the name of the CPG may not reflect the clinical situation. It was agreed to change it to '**Actual/Potential Shock from Blood Loss (trauma) – Adult**'.

It was felt that there were two possible entry points to the CPG;

- i) Clinical signs of shock post trauma, and
- ii) Mechanism suggestive of significant risk of haemorrhage.

Add a new decision box after Tranexamic Acid, 'clinical signs of shock' which will advise fluid administration.

The CPG will be amended be brought back for review as per the agreed process.

3.1.3 Anaphylaxis

Anaphylaxis had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review. Antihistamine medications for paediatrics may require updating of the 7th Schedule.

3.1.4 Pain Management

Pain Management had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.5 Glycaemic Emergency

Glycaemic Emergency had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.6 FBAO (Cricothyrotomy)

Cricothyrotomy had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.7 Haemorrhage Control (Scalp staples)

Scalp staples had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.8 Thiamine

Thiamine had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.9 ICD Disarm

ICD disarm had a level (ii) priority. It was agreed to update the relevant CPGs and bring back for review.

3.1.10 Early Warning Score

Early Warning Score had a level (i) priority. It was agreed that no action would be taken regarding progressing this item at this time.

3.2 Tachycardia CPG

In the absence of Gerry Bury, a concern was raised on his behalf; Amiodarone being indicated for a conscious patient is inappropriate.

David Menzies indicated that he felt the CPG was, whilst complex to teach, in the main fit for purpose.

Shane Mooney asked that a repeat Cardioversion be attempted if unsuccessful on first attempt.

As Amiodarone is indicated by the AHA and ERC as best practice for unstable ventricular tachycardia the committee supported its continued use by advanced paramedics.

The following suggestions were agreed;

Remove 'likely' from consider if VT box and add a new information box authorising an escalation of energy and subsequent cardioversion should the initial attempt be unsuccessful.

The CPG will be amended be brought back for review as per the agreed process.

In absentia, Gerry Bury also raised a concern about the indication for Amiodarone in the medication formulary. The indication as currently outlined 'Symptomatic Tachycardia (>150)' is too broad. It was agreed to insert 'ventricular' prior to tachycardia in the indications section.

4. Standards of Operations

Overview of the developments as follows;

4.1 Spinal Subgroup

The terms of reference of the Spinal Injury Sub Group were included in the meeting papers for approval. The following amendments were agreed;

- i) Remove the restriction on date for the literature review; 'since 2000'
- ii) Insert a 7th point; Integration with the wider healthcare services on spinal injury management.

Resolution

That the terms of reference of the Spinal Injury Sub Group be approved subject to the agreed amendments.

Proposed: Declan Lonergan **Seconded:** David Menzies

Brian Power indicated that a dedicated one day meeting focusing on spinal injuries, likely on the day of the May meeting will be held.

It was stressed that any decisions regarding future practice in relation to pre-hospital spinal injury management should be communicated to all stakeholders.

4.2 Local Injury Sub Group

The terms of reference for the group were included in the meeting papers.

Niamh Collins asked that those units not technically named LIUs are not excluded. It was suggested that the group define the current state of operation.

A fifth point was added to the terms of reference; Define ambulance transport decisions in general. *practice and*

Resolution

That the terms of reference of the Local Injury Unit Sub Group be approved subject to the agreed amendment.

Proposed: Joe Mooney **Seconded:** Macartan Hughes

4.3 Clinical Care at Events Sub Group

The terms of reference for the group were included in the meeting papers.

A 9th point was added to the terms of reference; To explore the responsibility and authority of the statutory ambulance services once contacted by the event organiser/ clinical care service provider at an event.

Resolution

That the terms of reference of the Clinical Care at Events Sub Group be approved subject to the agreed amendment.

Proposed: Shane Knox **Seconded:** Shane Mooney

The vice chair suggested that an email be circulated to members requesting those interested self-nominate to committees.

5. AOB

5.1 Macartan Hughes asked that the situation where by EMTs at events are being prevented from transporting patients be looked at. This will be considered by the Clinical Care at Events Sub Group. It was suggested that a control room manager be invited to partake in this group.

5.2 Rory Prevett raised a practitioner request that shock be changed to haemodynamic instability for in the Midazolam medication formulary. It was agreed that this was a training issue.

5.3 Niamh Collins raised the query that the Pain Management CPG currently indicated that it is acceptable that both IV Morphine and IN Fentanyl may be administered to the same patient. She raised a concern regarding the potential toxicity. Shane Mooney indicated that there were circumstances where the current dosing regimen were not always sufficient. David Menzies indicated that if the patient is in sufficient pain to merit the administration of both ^{to their} it is clinically sound. Niamh Collins remained adamant that the practice of administering both morphine and fentanyl is unsafe. ^{DB 28/5 max dose.}

5.4 Niamh Collins also asked the new patient health identifier will be launched this year and that MAC should be aware of any implications.

5.5 Richard Corbridge, CIO of HSE, should be considered to be invited to present to MAC.

5.6 David O'Connor raised a query from a practitioner requesting IO Lignocaine for non-arrests. It was confirmed that this would not be ^{su}perused at this stage.

Signed: _____

Date: _____ ^{pursued.} 28/5/15

