Medical Advisory Committee

Meeting Minutes

Osprey Hotel, Naas, 25/09/2014

In Attendance		**Apologies**	**Present**
Mick Molloy (Chair)	Derek Rooney	Cathal O'Donnell	Hugh Doran
Rory Prevett	Ken O'Dwyer	Dave Irwin	Brian Power
Joe Mooney	Peter O'Connor	Sean Walsh	Pauline Dempsey
David Hennelly	David Menzies	Valerie Small	
David O'Connor	Declan Lonergan	Shane Knox	
Shane Mooney	Niamh Collins	Jack Collins	
Conor Deasy	Gerry Kerr	Nial Reddy	
Michael Dineen	Gerry Bury		

1. Chairs Business

The Chair expressed his, and the committees sadness at the passing of Dr Geoff King. He asked that the executive pass on MAC's sincere condolences to his wife and family. A minutes silence was held in Geoff's memory.

Apologies received were noted. The chair informed the committee of the resignation of Dr. Seamus Clarke GP, from MAC due to the financial burden of having to employ a locum to cover his surgery for attending MAC meetings. The Chair suggested that Council be approached to see if a solution could be found, given the importance of GP representation on the committee. A concern was voiced regarding the singling out GPs whilst other members are attending at their own cost also. It was suggested that consideration be given to current regulations used within other state organisations.

2. Minutes

Resolution: The MAC approve the minutes of their meeting held on July 24th 2014, subject to the addition to Gerry Bury on the attendance list.

Proposed: Niamh Collins **Seconded:** Rory Prevett

Carried without dissent

2.1 Matters Arising

The Chair informed the committee that no further feedback from Prof Turner regarding obstetric CPGs has been received but this will be perused.

Brian Power informed the committee that the Health Products Regulatory Authority have confirmed that Practitioners are not obliged to report cases of adverse reactions but they request that they do so.

3. CPGs

3.1 RNLI Presentation

Dr Hugh Doran showed a brief video outlining the work of the RNLI. He informed the group that the organisation is not currently a recognised CPG service provider. The RNLI currently administer five medications (Oxygen, Aspirin, GTN, Entonox and Salbutamol) three of which are prescription only medications (POMs). They would now like to improve their legal footing in this regard.

As the RNLI in a UK based operation they take their standards from the UK governing body. Their emergency care training is called 'Casualty Care Course' which is between 20 and 24 hours in duration. Shane Mooney stated that all training carried out by the RNLI was by their UK based trainers who travelled to Ireland. Pauline Dempsey outlined that interaction between RNLI and PHECC has been on-going for several years and that their Casualty Care Course is closer to the OFA course in duration and content, but that the course teaches additional skills e.g. use of tourniquets and pressure points for haemorrhage control.

Brian Power outlined the legal position in relation to the administration of medications by practitioners. As RNLI are not CPG approved this does not apply to them, even though some of their volunteers may be PHECC registered practitioners. Brian also stated that under the current legal system there are two options for the RNLI in relation to POMs;

a) The medical officers within RNLI take responsibility for these medications and write a prescription for each medication administered within a 48 hour period.
b) The RNLI to become PHECC approved and only PHECC registered practitioners be permitted to administer the medications.

David Menzies asked if it was feasible to amend the legislation to administer these medications following an undertaking of a specialist course such as "EFR-marine" Brian suggested the development an exception register, which is ongoing with the DoH, may be of assistance to the RNLI when enacted.

Brian Power highlighted that other organisations such as mountain rescue and cave rescue are in a similar situation to RNLI. PHECC has been encouraging these organisations to become PHECC approved which will regularise their position, particularly in relation to POMs. The EFR-BTEC and the EMT-BTEC courses was designed specifically for organisations that are PHECC approved and working in austere environments. This was specifically to ensure some control was in place for the practice of these individuals, thus protecting the public. To approve RNLI for the additional skills without conforming to these standards will undermine the PHECC education standards.

Niamh Collins asked if a memorandum of understanding could be developed. Hugh Doran indicated that further communication between PHECC and the RNLI should help move things forward.

3.2 Medico Cork.

Conor Deasy gave an overview of the service operated in UCH Cork for the APs. He confirmed that the HSE indemnify the service. He went through the details presented in the MAC papers.

David Menizes enquired about how the quality of the advice given by doctors is monitored. Conor acknowledged that historically there may have been issues surrounding the quality of the service, however there is now the facility to record calls and funding has been allocated which will help the

quality of the service. He stressed the importance of the practitioners reporting negative experiences to the service as part of quality improvement.

Conor Deasy suggested that if a similar service be expanded to include paramedics, an AP placed in the control centre to screen calls and escalate there possible would be a good starting point. David Hennelly echoed the importance of a clinical decision desk within the National Ambulance Service.

David O'Connor suggested that the decimation of the medico-cork report to APs would be most worthwhile. Conor Deasy had no objection for the document being disseminated to APs.

3.3 CPG Prioritisation Process

A draft prioritisation matrix based on the suggestions of David Hennelly at a previous MAC meeting was presented in the meeting papers. Brian Power acknowledged the work carried out by Deirdre Borland on this matrix.

It was suggested that Patient Safety Categories would carry the most weight and that the top category should automatically make that topic a priority, provided it also scored high in likelihood of frequency/occurrence, regardless of the weighting in other domains.

Niamh Collins and Gerry Bury suggested thought be given to the evidence gathering around the development of CPGS and how best evidence based practice can be filtered to PHECC. It was stated that organisations similar to PHECC in other countries have a person employed to review journals on an ongoing basis to ensure currency of practice. Brian Power outlined the difficulty in relation to employment of new staff within the public sector and stated that PHECC is now down two staff. C.P.R. in Limerick were suggested as being tasked with this role.

Resolution: That the MAC Approve the prioritisation matrix subject to the agreed changes.

Proposed Ken O'Dwyer **Seconded** Michael Dineen

Carried without dissent

3.3.2 CPG development process

The meeting papers had documents from several sources outlining the development of clinical guidelines. A framework for CPG development was produced for the meeting. Gerry Bury welcomed the outlined process. It was suggested that the process be amended to read that someone be appointed to gather the evidence base.

The development process will be reviewed again at the next meeting. Gerry Bury suggested comparing the HIQA process with the PHECC process to ensure all areas were met to a recognised standard. Brian Power sought clarification on the direct involvement of PHECC in developing the CPGs as the funding body as this was an issue identified in almost all the guideline development documents. It was clarified that this only applies to funding organisations that had a potential conflict of interest and there was agreement that PHECCs direct involvement was appropriate. The Chair asked that members forward their suggestions for change in advance of the next meeting.

3.4 CPG development Forum

A report from the Centre for Pre-hospital Research (C.P.R.) on the CPG forum was included in the meeting report for the committee's information.

4. Practitioner queries re CPGs and medications

4.1 Paediatric hypoglycaemia care.

An email from Dr Ciara Martin to HSE NAS, detailing an issue of the administration of glucagon to a non-diabetic paediatric patient with hypoglycaemia was discussed.

The MAC agreed this was not a CPG issue and it was determined as a training issue and will be reverted back to NAS.

4.2 EMTs and IV maintenance

Joe Mooney relayed a query from an EMT regarding maintaining an infusion. Conor Deasy indicated that it was inappropriate to expect an EMT to transfer a patient with an IV infusion when they have not been trained in the any aspect of the workings of an IV infusion.

Gerry Bury, supported by Shane Mooney, outlined that such transports if not carried out by EMTs would clog up the system. Gerry Kerr asked if EMTs can be trained to maintain IVs. Brian Power suggested that training may be undertaken, but the licensed CPG provider is responsible for ensuring and maintaining competence of EMTs. In the interim either the infusion is turned off for the duration on the transport or the patient gets a medical or nursing escort.

Resolution: PHECC to write to EMT service providers and inform them, in the interest of patient safety, the direction from MAC is that; as it is outside their scope of practice if an EMT is the clinical lead during a transfer an IV infusion shall be turned off until the patient is handed over at the receiving facility. Also that the Education and Standards Committee be advised that MAC recommend that maintenance of IVs be included in the scope of practice of EMTs.

Proposer Peter O'Connor Seconded: Joe Mooney

Carried without dissent

4.3 Presentation of Dextrose

A practitioner enquired about carrying 20% Dextrose as it is available in smaller volume bags that the current 10% Dextrose. Gerry Bury suggested not amending the concentration carried as there was no clinical benefit and a greater risk of medication error. This was agreed by all.

5. HSE crowd event Guide

The chair suggested moving this to a future meeting to allow the committee to review it.

6. KPI

Brian Power informed the committee that Prof Ronan O'Sullivan has indicated that the KPIs are ready and awaiting academic publication. Gerry Bury strongly indicated that the information belongs to PHECC and should not under any circumstance be disseminated or published without approval. He further suggested that it may cause difficulty in the future for PHECC as the final outcome may be different when MAC makes its deliberations.

Concerns that Prof. O'Sullivan appeared to have has disseminated to HIQA without PHECCs permission.

Brian Power will review the memorandum of understanding for this project.

7. AOB

Gerry Bury informed the committee that he had issues with the current CPGs which he would be raising with the PHECC Executive. He raised concern with two issues on CPGs in particular, the cooling of patients post ROSC and the sedation of combative patients.

David Hennelly received an email from a clinical nurse specialist requesting a paediatric head injury CPG or a Paediatric significant nausea and vomiting CPG. He suggested that they be put through the prioritisation criteria. The chair suggested that this be looked at a future meeting.

David O'Connor stressed a concern that Cyclizine IM is written in the field guide and not in the CPG. He said it was unacceptable that the field guide and CPG does not match as it could leave a practitioner open to fitness to practice if they use an inappropriate route of administration. Brian Power will follow up regarding this matter.

Next meeting will be held on October 23rd in Naas.

Signed