Medical Advisory Committee

Meeting Minutes

30th January 2020, PHECC offices @ 10:00am

Present
David Menzies (Chair)
Martin O'Reilly
Eoghan Connolly
Niamh Collins
Peter O'Connor
Cathal O'Donnell
Ian Brennan
Stanley Koe (absent for agenda items 1, 2 & 7)
Shane Mooney
Hillery Collins
Philip Darcy
Dr Tomás Barry (substitute for Gerard Bury)

Teleconference
David Irwin (Vice Chair)
David Hennelly (absent for agenda items 5, 6, 8, 9 & 10)

Apologies
Gerard Bury
Macartan Hughes
Jason van der Velde
Mark Dixon
Mick Molloy

Non-Attendance
Lisa Cunningham Guthrie
Shane Knox

In Attendance
Brian Power, PHECC PDO
Ricky Ellis, PHECC PDO
Margaret Bracken, PHECC Committee Officer

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1. Chair's Business

The Chair welcomed everyone to the meeting. Apologies were noted. The Chair introduced and welcomed Dr Tomás Barry who was a substitute member for Gerard Bury for this meeting.

2. Minutes from November 2019 meeting

The minutes of the meeting held on 28th November 2019 were reviewed. An amendment was agreed to agenda item 5.1 Community Paramedic.

Delete; 'It was stated that the CP programme is designed solely by NAS and there should be broader consultation with other services. It was suggested that the CP programme be pursued as a PHECC designed programme.'
Replace with; 'It was stated that currently the only Community Paramedic programme is the NAS pilot and it was agreed that Community Paramedic be pursued as a PHECC project going forward.'

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 28th November 2019 subject to the agreed amendment.

Proposed: Ian Brennan **Seconded: Philip Darcy**
Carried without dissent

2.1 Matters arising

- An update was requested on the PHECC practitioner engagement day, agreed for 18th March, to enable PHECC practitioners to engage with MAC members. Brian Power relayed that he is in discussions with two venues within the Naas area and will confirm the venue when these are completed.

- A publication date for the 2020 CPGs was queried. It was stated that, should publication of the new CPGs be delayed, the recognised institutions and approved training institutions will have to be notified. Brian Power stated that CPGs already recommended by the MAC to Council have been approved and are awaiting release. When the remaining CPGs are finalised by the Committee and approved by Council the full suite of CPGs will be ready for release. It was estimated that publication date will be Q3/Q4 of 2020. It was suggested that the Committee have a final review of all CPGs prior to publication.

- An update was requested on the Emergency Obstetrics CPGs. At the November 2019 MAC meeting it was agreed that further review of the CPGs and further engagement with the National Clinical Programme for Obstetrics and Gynaecology was required. Brian Power relayed that he has contacted Dr Mary Higgins who is arranging a meeting with Dr Jenifer Donnelly, Rotunda, to progress the CPGs and a response is awaited.

3. CPG Development Process

3.1 Sedation/analgesia CPGs

David Hennelly provided an overview. A discussion document and draft CPGs were included in the meeting papers. At a previous meeting the MAC agreed terminology to be used to define the levels of sedation in future PHECC CPGs/education and training standards, and the Richmond Agitation-Sedation Scale (RASS) as the standard sedation assessment tool for pre-hospital care in Ireland, as set out in the document.

The five levels of sedation as presented in the papers were agreed in principal. Discussion arose as to what the minimum practitioner clinical levels should be to perform the various levels of sedation. While it was agreed that EMT level was appropriate for level 1 'minimal sedation-anxiolysis' all the other sedation levels required at minimum an AP. It was stated that practitioner training and practice at AP level will be required. It was felt that level 4 'General Anaesthesia' and level 5 'Dissociative Sedation' would require a higher skill level and may be more appropriate for a specialist paramedic such as critical care paramedic. Level 2 'Moderate Sedation/Analgesia' and level 3 'Deep Sedation/Analgesia' may be suitable as a qualifying procedure for AP upskilling. It was advised that a tight clinical governance structure will need to be put in place. It was suggested that, as not all APs might be comfortable to practice these procedures nor may not have the necessary experience, it could be optional scope of practice with competency being attained. The consensus was that a significant majority of experienced APs, but not all APs, could be trained to up to and including level 3 'Deep Sedation' for severely agitated patients. It was suggested that level 3 'Deep Sedation/Analgesia' be introduced as a post graduate skill for APs with a number of years' experience and not for AP interns. Robust safety procedures and an education with strong guidelines for practitioners would be required. It was suggested, for legal reasons, that standard operational procedures, with medical oversight, be put in place to support practitioners. It was stated, to ensure that the right calibre of practitioners are practicing sedation, they be privileged by a licensed CPG provider who can decide whether medical oversight is required or not.

The draft CPGs as contained in the discussion document were discussed. David Hennelly acknowledged Ray Carney for his assistance drafting the CPGs. It was suggested that level 3 'Deep Sedation' could be a non-core CPG or a CPG with a non-core element. It was suggested that the draft sedation CPGs, particularly level 4 and 5 be reviewed and refined by the critical care paramedic subgroup.

The members commended David Hennelly and acknowledged the excellent work he has done to date.

3.2 Pain management CPGs

David Irwin provided an update. As part of a literature review the subgroup has identified a significant number of papers published within the past five years and they will review these. David extended an invitation to join the subgroup to the members. The subgroup reviewed international CPGs around pain management and agreed that the template used for the Ambulance Victoria CPGs are the best suited to PHECC CPGs. A summary and draft CPGs will be presented at a future MAC meeting.

4. Clinical Developments

4.1 Advanced Airway Registry

UL Hospitals Emergency Intubation Guideline and ED Airway Registry was included in the meeting papers for information. Brian Power stated that this standard could be a method used to measure practitioner success or otherwise of intubation in the pre-hospital setting. Practitioners would log onto a portal and anonymously provide their experience of intubation. The data would inform whether or not to continue with the practice of intubation. A discussion ensued. It was noted that the ePCR captures this data and practitioners may not want to voluntarily log onto a portal and provide this information.

The consensus was that this is an excellent standard which should be supported and introduced. The development of a structured form for intubation was suggested. It was suggested that there could be a PHECC register set up for pre-hospital intubation with a governance structure to support it. It was advised that this would form part of the current PHECC register and a new register would not be necessary. It was recommended to examine the existing data and ascertain where to go from there. Brian Power relayed that responses he has received from the medication and skills survey have been broken down into the three clinical levels however it will take time to analyse the data. This data can then be utilised to help make informed decisions.

4.2 Hyperkalaemia CPG

Proposed PHECC CPG 'Pre-hospital treatment of Acute Hyperkalaemia' for Paramedic and Advanced Paramedic levels was included in the meeting papers. This agenda item was deferred.

4.3 Pre-hospital treatment of Rhabdomyolysis

A review from a PHECC Advanced Paramedic on pre-hospital treatment of Rhabdomyolysis in falls, with suggestions for changes in the CPGs, was included in the meeting papers. This agenda item was deferred.

4.4 Update on declined treatment and/or transport wording

Shane Mooney provided an overview. A draft narrative from the Declined Treatment and/or Transport section of the 2017 Field Guide with additional wording from Martin O'Reilly was reviewed at the January

Quality and Safety Committee meeting. Following discussion the Committee agreed that the narrative needed to be strengthened and some amendments were made. The Committee directed that PHECC seek legal advice to ensure that the amended wording protects the practitioner.

The members discussed the revised wording as included in the meeting papers. It was stated that practitioners cannot leave patients who lack capacity and their duty of care remains until An Garda Síochána, a GP or a relative arrive to take responsibility for the patient. It was stated that protecting practitioners is paramount and that legal advice is required. It was suggested that PHECC could engage with An Garda Síochána following receipt of legal advice.

Following discussion, amended wording was agreed for patients who have not demonstrated decision-making capacity.

- Replace 'lacks the capacity to make that decision' with 'has not demonstrated decision-making capacity'.
- With regard to handing over care, it was suggested to delete 'another healthcare professional'.

If 'No to any of the above, the patient has not demonstrated decision-making capacity at that time and is deemed not to possess current decision-making capacity. The practitioner's duty of care remains until the patient is handed over to the care of An Garda Síochána, a GP or an adult who has taken responsibility of the patient.

Brian Power will make the amendments as agreed. The MAC recommend that the Quality and Safety Committee and Council seek legal advice on the wording.

5. Clinical Queries

The following clinical queries from PHECC practitioners were included in the meeting papers for consideration of the MAC. The Chair requested that, due to the large volume of clinical queries received, all queries be presented to the Chair prior to inclusion in the meeting papers.

5.1 Cardiac arrest; presumed consent for organ harvesting

From a NAS intern paramedic and CFR responder and instructor, in relation to the government decision to pursue a presumed consent or opt-out in relation to organ donation. The MAC are asked to consider would PHECC be reviewing the current situation whereby in an out of hospital cardiac arrest, where the criteria have been met and a decision to cease resuscitation is made, that a decision would be made to continue with ALS with a view to organ harvesting. There is an ethical situation whereby the reason to intervene in the first case is to hopefully achieve a ROSC.

Following consideration, it was agreed that we need to follow the current organ donation process facilitated by Organ Donation and Transplant Ireland.

5.2 FBAO management – Laryngoscopy for paramedic scope of practice

From a DFB paramedic who identified several cases and encountered another situation when a choking patient went into arrest because of FBAO. An advanced paramedic was requested and CPR in progress. The MAC are asked to consider the use of laryngoscopy and Magill forceps as a paramedic skill as it would be beneficial if not crucial for patient's outcome under these circumstances.

A discussion ensued. It was stated that this is a straightforward procedure and an easy way of dislodging an object from the airway. Training needs, the clinical skill levels required, and whether there is a requirement for a new CPG was considered. It was stated that current data is not adequately capturing choking leading to cardiac arrests. The consensus was that the use of laryngoscope and Magill forceps as a paramedic skill would be beneficial. It was agreed that Laryngoscopy for paramedic scope of practice be put on the risk matrix and supporting evidence be sought. To be discussed at a future MAC meeting.

5.3 Patella re-location for EMTs

From a practitioner who recently encountered a series of patients with lateral patellar dislocations. The vast majority of vehicles responding to these incidents in Dublin are paramedic crews. With the current scope of practice these providers are capable of attempting reductions utilising the same pain management CPG and medication matrix available to EMTs. Based on the AMPDS standard these calls are generally categorised as Bravo and Charlie calls. EMTs, particularly at events, are often the most likely responders on scene. The MAC are asked to consider patella re-location for EMT scope of practice.

Following discussion it was agreed that the MAC do not consider patella re-location appropriate at EMT level. Brian Power will inform the practitioner.

5.4 Half-life of medications; include in medication formulary

A case study was outlined where a patient was administered Midazolam by a relative and a subsequent event occurred in the ED. MAC are asked to consider including the half-life of medications into the PHECC medication formulary to heighten awareness of the time to eliminate a medication from the system.

A discussion ensued. It was stated that half-life should be consistent and the effect of the medications on the patient is what is important. Following consideration it was agreed that the solution provided in the query does not answer the issue raised, and the clinical effect of the medications administered is what matters. Brian Power will inform the practitioner.

5.5 Recognition of major trauma in the elderly

Report on trauma assessment in the elderly and proposed guidelines submitted for consideration of the MAC. The most common place and mechanism of injury for major trauma is in the home with a fall of less than 2 metres. This low energy mechanism may not alert pre-hospital practitioners to the possibility of major trauma. Current pre-hospital triage systems may not account for the different physiological responses of the older patient. Trauma in the elderly is not currently a learning objective on PHECC educational standards for EMT, Paramedic or Advanced Paramedic courses.

A proposed sticker for the PHECC field guide was included in the report. A proposal was made to the NAS medical directorate to adopt a Silver Trauma Assessment tool incorporating and adapting material from several sources. This could be printed on a sticker and added to Practitioner Reference Material while an education program is being designed and a decision is pending. Implementation of a silver trauma protocol has workload implications for ED senior clinicians. Further study should be carried out to optimise accuracy of any adopted protocol. Ambulance patients, in this cohort, not conveyed to hospital have twice the mortality rate of those who are transported to hospital.

A discussion ensued. It was stated that this has relevance to the trauma network guidelines. It was noted that the AMPDS are receiving more trauma calls for elderly patients. It was agreed that elderly patient care pre-hospital requires further discussion at a future MAC meeting. The MAC commended the author and acknowledged the significant amount of work put into the report. Brian Power will communicate this to the author.

It was agreed that the CPG prioritising matrix would be circulated to all MAC members in relation to the deferred items to facilitate development of new CPG if appropriate.

6. Correspondence

6.1 Medications and Pregnancy

Correspondence from a PHECC practitioner with a suggestion pertaining to the safe use of medications for use during pregnancy, for the upcoming update of the PHECC CPGs and field guide, was included in the meeting papers. The practitioner feels that it would be a good idea and extremely helpful to all practitioners if a Traffic Light System for safety with medications is highlighted on the CPGs beside each reference where a medication is indicated, and also on each page of the medication formulary and the field guide.

Brian Power advised that, from a PHECC perspective, if a Traffic Light System was added to the CPGs then a considerable increase in workload would ensue for the PHECC staff to ensure accuracy of this process. Practitioners are required to check every medication as part of the rights of medication administration. He stated that it is preferable to identify medications that cause a risk to pregnant patients through the field guide and medication formulary. He stated that the medications with pregnancy concerns associated with them did not include a life-threatening situation where medications have to be administered to a pregnant patient immediately, and there would be sufficient time to check the field guide. It was suggested that instead of a colour code, which may pose a risk to those with colour blindness, a symbol could be considered. It was agreed to further discuss highlighting CPGs with medications that may be contraindicated during pregnancy at a future MAC meeting.

6.2 Quality and Safety Committee resolution for MAC – Change DNR to DNAR*

At their September 2019 meeting the Quality and Safety Committee discussed terminology on ‘do not resuscitate’. The Committee agreed that it is appropriate that PHECC would be consistent with national policy taxonomy on this matter; HSE, 2013, National Consent Policy, Part Four—Do Not Attempt Resuscitation (DNAR). The Committee recommend to the MAC that DNR be changed to DNAR on the PHECC DNR Clinical Practice Guidelines and all necessary documentation.

A discussion ensued. It was stated that the Department of Health and all other HSE publications use the term DNAR, and for consistency PHECC should be using this term also. The MAC agree with the recommendation of the Quality and Safety Committee. Brian Power will make the necessary amendment to the PHECC DNR CPGs and all necessary documentation.

Subsequent to discussion the following resolution was passed.

Resolution: That the Medical Advisory Committee approve the Quality and Safety Committee recommendation that DNR be changed to DNAR on the PHECC DNR Clinical Practice Guidelines and all necessary documentation.

Proposed: Eoghan Connolly **Seconded: Hillery Collins**
Carried without dissent

6.3 Priority Dispatch Committee resolution for MAC – Specify medication administration that warrants a Red response*

The Priority Dispatch Committee, at their January meeting, reviewed the EMS Priority Dispatch Standard and discussed the definition of a Red determinant under DCR table rules. A query was raised as to whether all medication administration would warrant a Red response. It was agreed to delete '(other than OTC medications)' and add 'as per Medication Annex agreed by the Medical Advisory Committee.' Annex of medications requiring a Red response was included in the meeting papers.

Brian Power provided the rationale for the change to the priority dispatch standard. To date Red determinants have been designated using expert consensus opinion and not evidence based, resulting in 46% of 112 calls receiving a Red response. This is a significant strain on resources for the statutory services and the HIQA response time standards have not been met as a result. Recent research in the UK has identified that using retrospective analysis on actual 112 incidents and matching them with the DCR codes, they have succeeded in a significant decrease in Red responses. The process is to match the DCR codes with incidents where an airway, breathing or circulation problems have been identified and also where a medication has been administered thus justifying a Red response. The Priority Dispatch Committee felt that the administration of any medication was too broad a criterion and that only specific medication administrations would warrant a Red response. As a result they sought advice from MAC as to which medications should be included as a criterion for a Red response.
A discussion ensued. It was stated that there is a danger of under triaging as well as over triaging. Concern was expressed about downgrading or upgrading a response being decided based on whether a patient got a medication or not. It was stated that it is far more complex and a decision cannot be made solely based on this criteria. Brian Power advised that feedback received from practitioners report that a high proportion of Red responses to which they are dispatched are not life threatening situations. He advised that this process is evidence based and will be made possible in Ireland through the introduction of the ePCR. He advised that there will need to be an implementation phase for this new priority dispatch standard. Shane Mooney concurred with the high levels of inappropriate Red responses being dispatched and advised that addressing this issue would be beneficial to pre-hospital emergency care provision.

It was noted that PHECC PCRs do reflect how many red response calls resulted in administration of medications and treatment. It was stated that AMPDS is not perfect and is not supposed to diagnose. It was suggested to examine the data from NAS and DFB to determine if the reality is matched with practitioners experiences. It was stated that the ProQA questions need to be tightened up and the primary starting question needs to be clearer.

Subsequent to discussion, the MAC refer Annex C; medications requiring a Red response, back to the Priority Dispatch Committee for further review. The MAC are happy to work with the Priority Dispatch Committee to refine Annex C.

6.4 PHECC practitioner and GP practice

As a result of several queries to the PHECC office the MAC are asked to deliberate on; whether a PHECC registrant may be employed or volunteer in a GP practice or a primary care practice while carrying out a paramedic role and duties as per CPGs under the authorisation of a registered medical practitioner within the practice; whether there is anything preventing a GP practice or primary health centre to become a licensed CPG provider. Individual practitioners are privileged by licensed CPG providers to perform clinical interventions according to their scope of practice. Prescription only medication administration, on the other hand, is regulated for PHECC practitioners by the Seventh Schedule. For each medication the authority is either 'According to CPG' or 'On registered medical practitioner's instructions'. A GP (a registered medical practitioner), therefore, may give instructions to a PHECC practitioner in relation to the administration of a specific medication. Current practice for PHECC practitioners, however, is subject to the triple lock.

Following consideration, the MAC agreed that this is a governance issue and is not within the remit of the Committee.

7. MAC Strategy 2017-2020

7.1 Community Paramedic

At the November MAC meeting it was agreed that the MAC support the Community Paramedic report, as submitted by the Community Paramedic subgroup, in principle, but a more detailed scoping document is required. It was agreed that the Community Paramedic subgroup be reconvened in order to draft a scoping document aligned with the strategic development subgroup terms of reference, for submission and further review. Hillery Collins, Chair of the subgroup, relayed that he had hoped that a community paramedic would be available to present to the Committee. Ian Brennan offered to assist the subgroup with drafting a scoping document and he will liaise with Hillery. It was suggested that it would be beneficial to have a primary care person join the subgroup. The Committee agreed that a general practitioner on the subgroup would be very beneficial.

7.2 Critical Care Paramedic

The Critical Care Paramedic subgroup scoping document was presented to Council at their December meeting with a recommendation from the MAC that the document be approved as a policy and to progress to an implementation strategy. The Chair informed the members that Council support the development of a Critical Care Paramedic and propose the creation, through primary legislation, of a 4th division of the practitioner register at the grade of specialist paramedic.

Ian Brennan, Chair of the subgroup, provided an update. The Critical Care Paramedic subgroup are currently drafting CPGs and modifying the scope of practice. Ian suggested seeking funding from Council for a Programme Development Officer to manage the project going forward. The Chair stated that PDO support will be needed at some point and the subgroup can work with the PDO. The Chair will bring this recommendation to Council at their February meeting. It was stated that designing education and training standards for the critical care paramedic will be the next step and the Education and Standards Committee will be consulted. A discussion ensued on the development of a specialist paramedic practitioner subgroup which could incorporate the critical care paramedic and community paramedic where there would be a lot of cross over and synergy.

7.3 Treat and Referral

At the November MAC meeting the Committee recommended supporting the development of an enhanced range of treat and referral CPGs, including but not limited to hypoglycaemia and seizure management, to Council for approval. Brian Power relayed that there was not enough time to present his report at the December Council meeting and his presentation was deferred to the February meeting. He advised that an implementation plan will be required. The members discussed which CPGs would be beneficial for treat and referral. It was stated that treat and referral CPGs will have to be safely defined and focused and practitioner training will have to be provided. It was stated that the criteria should be relatively straightforward and measurable and relate to common procedures. It was agreed that a Delphi process be completed to identify appropriate clinical presentations that may benefit from a treat and referral clinical care pathway.

It was stated that hundreds of patients are being transported to Emergency Departments on long journeys for relatively simple procedures like catheter changes. Ambulance control is receiving calls for ambulances to be sent to patients who do not require an ambulance and can travel to an ED by car. It was suggested to examine control room data and examine what are the chief complaints of people not travelling to the ED, and also to examine evidence from DFB and NAS PCRs.

8. Clinical Practice at Events

There was no update.

9. External communications, consultation, feedback

9.1 NAHM Annual Report 2018

The National Audit of Hospital Mortality Annual Report 2018 from the National Office of Clinical Audit was included for information. Brian Power stated that presently there are no mortality measurements directly attributed to pre-hospital emergency care practice. The National Audit of Hospital Mortality focused on acute conditions which are encountered by PHECC practitioners and there is an opportunity to differentiate between hospital mortality rates for patients that are transported by ambulance and those that self-present to the ED. This, if proven, could definitively attribute good pre-hospital emergency care practice to reduced mortality. It was suggested that this could merit a research project funded by PHECC. It was stated that Council have approved funding for research. It was agreed that further consideration by the MAC is required on hospital mortality rates with the possibility of submitting a request for research funding to Council.

10. AOB

10.1 Tabled documents submitted from Cathal O'Donnell and Gerard Bury on the Novel Coronavirus were circulated. The HSE Health Protection and Surveillance Centre (HPSC) and NAS have devised a Novel Coronavirus Risk Assessment Tool for use by ambulance personnel. Cathal O'Donnell stated that this is a dynamic situation and we need to be on par with the HPSC. He advised that that NAS, DFB, Dublin Airport Authority and the Irish Coastguard are working together in this instance. He advised that the HSE HPSC website is updated regularly. Brian Power was requested to respond to Gerard Bury advising him that the HPSC is looking after this issue. It was suggested that a link to the HSE HPSC website could be uploaded onto the PHECC website. It was agreed that all licensed CPG providers be informed by PHECC of the HPSC advice and that is to be the source of information as the situation unfolds.

10.2 Ricky Ellis sought direction from the MAC with regard to the roles and responsibilities of a licensed CPG provider Medical Director. He stated that the only current requirement for a Medical Director is to be registered in Ireland. He noted that MAC have never determined the roles and responsibilities of a Medial Director. The Chair advised that this is an issue for Council in the first instance and it will be considered by the Committee if referred by Council.

There being no other business the meeting concluded at 13:45pm approximately.

The Chair thanked all present for their attendance.

The next MAC meeting will be held at 10:00am in the PHECC offices on Thursday 19th March 2020.

Signed: _____ **Date:** **28th May 2020**

Chair