Pre-Hospital Emergency Care Council

Medical Advisory Committee

Meeting Minutes 26th May 2017

PHECC office, Naas

In attendance	Apologies	Present
David Menzies Chair	Gerard Bury	Brian Power PHECC
Shane Knox	Lisa Cunningham	Margaret Bracken PHECC
Macartan Hughes	Niamh Collins	
David Irwin		
Ian Brennan		
Jason van der Velde		
Hillery Collins		
Mick Molloy		
Shane Mooney		
Martin O'Reilly		
Peter O'Connor		
Cathal O'Donnell		
David Hennelly		
Eoghan Connolly		
Mark Dixon		
Stanley Koe		

1. Chair's Business and Introductions

The Chair opened the meeting and welcomed everyone, introductions were made and apologies were noted. The Chair proposed that the Committee meet for a full day every second month with agreement from the members. The recent bombing in Manchester was noted, and the members expressed their solidarity and sympathies to everyone involved and to the NWAS.

2. MAC Terms of Reference – TOR012

Brian Power briefed the members on the new MAC terms of reference which were included in the meeting papers. Taking cognisance of the terms of reference used by similar regulatory bodies in other jurisdictions and the results of a survey, which was responded to by members of the previous MAC and Council, a draft new terms of reference was compiled and presented for Council approval. Following deliberations Council approved the current terms of reference at its April 2017 meeting.

Specific points from the terms of reference were highlighted, particularly for the new members of MAC. Exercising due diligence in all matters, attendance at meetings and the importance of confidentiality were brought to the attention of the members. Members were advised that consensus on decisions was the aim, however in the absence of consensus a straight vote would apply. Members were also asked to be aware that the Chair does not have an independent vote but only a casting vote in tie situations. The terms of reference will initially be reviewed by MAC at the end of the first year. Recommendations to modify the terms of reference will require approval of Council. Finally, should any conflicts of interest be identified they will be managed appropriately.

2.1 Corporate Governance

Extracts from the "Code of Practice for the Governance of State Bodies" from the Department of Public Expenditure and Reform were included in the meeting papers and the Chair gave a brief outline to the members. Brian Power informed the members that the full document can be made available. The Chair called for nominees for the post of vice-chair of the Committee in accordance with the terms of reference. David Irwin was the only nominee and was deemed duly elected.

3. Clinical Queries

3.1 $ETCO_2$ for sepsis assessment

An email from a Paramedic to the MAC regarding the possibility of introducing $ETCO_2$ levels < 25mmHg as one of the SIRS markers in the Sepsis CPG was discussed among the members. The members noted that this is a very well presented question and Brian Power will feed this back to the Paramedic. However, no evidence of improved patient outcomes was noted in relation to the use of $ETCO_2$ in this situation and no change in the CPG was recommended.

It was pointed out that the Sepsis Programme are producing new sepsis guidelines and the involvement of PHECC on the Sepsis Committee was discussed. Brian Power advised that PHECC have no direct involvement or representative on the Sepsis Clinical Care Programme. A discussion ensued and it was agreed that the Chair will write to the Sepsis Committee regarding representation from MAC. The Chair requested a nominee and Macartan Hughes put himself forward as the MAC representative should this be acceptable to the Sepsis Clinical Care Programme.

3.2 Emergency Tracheostomy Management

An NHS (UK) flowchart by Dr Philip O'Donnell used for emergency tracheostomy management was included in the meeting papers and Cathal O'Donnell briefed the members. It was highlighted that upskilling is due to be carried out in the National Ambulance Service shortly and this process may be of benefit. After considerable discussion, the CPG prioritisation matrix was applied with a high weight scoring, and the consensus among the members is that a CPG is warranted. Brian Power will draft a CPG to be discussed at the next MAC meeting on 30th June, and make a request to CPR University Limerick and Clinical Nurse Managers in St. James's Hospital to look at the evidence, also Dr Philip O'Donnell will be consulted. David Irwin and Mark Dixon offered to assist in the drafting of guidance on this matter.

3.3 Anti-emetic during pregnancy

An email from Macartan Hughes on the issue of anti-emetics during pregnancy, with an extract from the JRCALC 2016 guidelines, was included in the meeting papers. The members discussed adding Metoclopramide to the medication formulary to alleviate unpleasantness for expectant mothers during long transport. It was agreed that a new CPG was not immediately required and Metoclopramide will be recommended to be added to the Seventh Schedule. David Hennelly agreed to send the NAS memo in relation to medications and pregnancy. A draft position paper will be developed by PHECC on medications used for pregnancy for further discussion.

3.4 Methoxyflurane education material

Information from Dr Sarah Dolan, Medical Manager, Galen Limited, on the safe and effective use of Methoxyflurane (Penthrox) was included in the meeting papers for information. A discussion ensued on the requirement to present a patient alert card following Methoxyflurane administration as outlined in the information pack. There was broad agreement that this was not required for PHECC practitioners as patient care would be handed over to receiving Emergency Department staff.

Discussion also occurred on the fact that Methoxyflurane is unlicensed for paediatric use and some concern was expressed regarding the dose in the CPG. After discussion, it was agreed that no change in the CPG was needed.

Cathal O'Donnell suggested that MAC liaise with the HPRA on the use of unlicensed medications in general.

3.5 Naloxone for SI 449

A letter from the HSE National Social Inclusion Office to the PHECC Executive seeking clarity on the administration of Naloxone as per SI 449 of 2015, and a response letter from the Director of PHECC, were submitted with the meeting papers for discussion. The HSE request clarification on the differences between the authorised licensed use of Naloxone as per SmPC guidelines and PHECC CPG 1.3.6 Listed Organisations and Naloxone – Adult. The number of doses was also queried. The members noted that a specific product (1 mg/mL pre-filled syringe) is specified by the Tenth Schedule and not a generic medication as specified for all other medications on the Tenth Schedule.

There was robust discussion and the committee members felt that as focus must be on safety, the issue of multiple use of the same needle was not acceptable. The consensus was to permit repeated doses of 0.4 mg prn at 2 minute intervals, however only if a different needle is used for each dose. The meeting also concluded that reversal of an opioid overdose for a patient who is breathing adequately is not acceptable for two reasons;

a) It is not indicated as per all PHECC CPGs i.e. 'Unresponsive and inadequate respirations following suspected opioid OD'
b) It has potential for responder safety as the patient may become aggressive following reversal.

Action items:

1. write to the HSE National Social Inclusion Office thanking them and advising them that after careful consideration the MAC is recommending that multiple doses of Naloxone 0.4 mg may be administered at two minute intervals, provided that a different needle is used and that the indication for Naloxone administration remains unchanged:- Unresponsive and inadequate respirations following suspected opioid OD. This means that as two needles are supplied with each pre-filled syringe only two doses may be administered per pre-filled syringe.
2. write to DoH requesting that the specific concentration of Naloxone should be replaced on the tenth schedule and to including IN as an option to improve safety.
3. write to UL seeking the evidence base for dose and route of Naloxone
4. amend CPG 1.3.6 Listed Organisations and Naloxone (adult) and add the following:
   - For Naloxone, add 'repeat prn every 2 mins' and 'one dose per needle'
   - On the patient breathing arm of the CPG add; 'follow instructions from ambulance call taker'

3.6 Clinical Practice Procedures

An email from a registered AP to PHECC regarding the possibility of developing Clinical Practice Procedures in the form of an app and/or pocket book was discussed. Following discussion, it was agreed that is was appropriate for PHECC to develop a CPP manual.

Resolution: That the Chair of MAC recommend the development of a Clinical Practice Procedure manual to Council and request funding for same.

Proposed: Mark Dixon **Seconded:** Macartan Hughes
Carried without dissent

3.7 Risk associated with 2017 CPGs

An email from a registrant with concerns regarding sedation, on the CPG 4/5/6.4.30 Behavioural Emergency without monitoring of $ETCO_2$. He also expressed concern about the use of supraglottic airway devices without monitoring of $ETCO_2$. It was agreed to amend CPG 4/5/6.4.30 to include '$ETCO_2$' to the box under Midazolam but not to include $ETCO_2$ for supraglottic airway as that would totally restrict their use.

3.8 Paediatric traumatic brain injury CPG

Included in the papers was an email from a registrant seeking clarity on CPG 4/5/6.7.11 Inadequate Ventilations – Paediatric, which directs the practitioner to go to Head Injury CPG, in the case of a brain insult/head injury. The concern raised was that there is no paediatric head injury CPG. Following a discussion it was agreed to add a Paediatric coma score to CPG 5/6.6.5 Head Injury – Adult and re-title the CPG to 'Head Injury'. The same parameters could be used for the specific GCS for both adult and paediatric. Stanley Koe to send paediatric GCS to Brian Power for inclusion into the CPG.

3.9 Defibrillation policy

An email from Martin O'Reilly regarding the 2017 CPG Defibrillation Policy was included for discussion. Martin relayed his concerns about the change of wording from the 2014 Defibrillation Policy "Paramedics **may** use manual defibrillation for all age groups" to the current wording "Paramedics and advanced paramedics **should** use manual defibrillation for all age groups". The consensus among the members was to revert to the original wording of 'may' for paramedic defibrillation.

Resolution: that MAC recommend to Council to amend the Pre-Hospital Defibrillation Position Paper to read "paramedics may consider using defibrillators in manual mode for all age groups"

Proposed: Mick Molloy **Seconded:** Peter O'Connor
Carried without dissent

3.10 Insulin pumps

Included in the meeting papers was an email submitted from a registered EMT seeking guidance on what to do with an ALOC patient with low blood sugar levels who has an insulin pump. Following discussion among the members it was agreed to add an information box to the Glycaemic Emergency CPGs with 'check for presence of insulin pump and if hypoglycaemic stop or remove the pump'.

3.11 Midazolam for Paediatrics

An email from an Advanced Paramedic to Cathal O'Donnell querying the administration of buccal Midazolam to a child under 3 months was discussed. The current medication formulary refers to < 1 year only. After discussion it was agreed to amend the medication formulary for Midazolam for paediatrics to include: '< 3 months - 1.25 mg buccal' and '< 1 year to 3 months - 2.5 mg buccal'. As this was deemed an urgent medication change with a potential patient safety issue a decision was made to refer this change direct to Council for approval.

Resolution: That MAC recommends to Council an immediate change to the Seizure/Convulsion – Paediatric CPG of the Midazolam dose '< 3 months - 1.25 mg buccal' and '< 1 year to 3 months - 2.5 mg buccal'.

Proposed: Mick Molloy **Seconded:** Shane Mooney
Carried without dissent

4. Correspondence

4.1 email from a GP re Adrenaline

Mick Molloy informed the members that a GP wrote to him seeking a letter of support from PHECC to the HSE to provide education, training and medications for GPs to treat anaphylaxis in children. Following discussion among the members the consensus was that this lies with the ICGP as the regulator for GPs. The Chair of MAC to write back to the GP informing him that this is not in PHECC's remit.

4.2 email from DoH re Oxygen for CFRs

In response to an email from Brian Power to the DoH with a recommendation from MAC to add Oxygen and Methoxyflurane to the tenth schedule the DoH have requested evidence based rationale and justification for this. Brian Power informed the meeting that PHECC had written to C.P.R. seeking evidence for the inclusion of these medications in the tenth schedule. A strategy will be put in place by MAC and mapped out for the next 3 years.

5. Clinical Developments

5.1 Position paper on Critical Care Paramedic

Brian Power informed the members that the position paper on the 'Utilisation of Critical Care Paramedics for critical care transfers' was produced for the National Transport Medicine Clinical Care Programme 3 years ago and is included in the meeting papers for discussion purposes. It was pointed out that the position paper is a historic document and was also brought to the Education and Standards Committee 2 years ago. A discussion ensued and the report was acknowledged by the members as a good and comprehensive piece of work. Concerns were raised regarding the language used on page 4 referencing the National Ambulance Service, as it is felt by the Medical Director of the NAS that this paragraph does not represent the views of the NAS.

Concerns were also raised about the use of the title 'Critical Care Paramedics' as this report is aimed at inter-hospital transfer. Extending the skill set of paramedics to provide critical care at the roadside and in particular for aeromedical transports was discussed.

5.2 HSE NAS Community Paramedic project

Brian Power outlined the process whereby PHECC were requested by HSE to support a European Union funded project to develop a small cohort of community paramedics in Scotland, Northern Ireland and Ireland. Cathal O'Donnell briefed the members on the scope of practice of the community paramedic in this project. The possibility of extending the skill set for community paramedics and developing specific CPGs was debated. The general opinion among the members was that a stronger framework was needed with advanced skills and decision making.

6. CPG Development Process

Brain Power gave an overview on the CPG development process.

The following were included in the meeting papers for information and discussion.

6.1 CPG development policy – legal basis

POL023 – Clinical Practice Guideline (CPG) – Development Policy.
The members were informed that the Chair of MAC signs off on new CPGs based on the process built into the CPG development policy.

6.2 JRCALC standard for guideline development

UK Ambulance Services Clinical Practice Guidelines standard for guideline development

6.3 JRCALC CPG development process

An overview of UK Ambulance Services CPG development process.

6.4 AGREE II instrument user manual

Appraisal of Guidelines for Research & Evaluation II

7. Clinical Care at Events

7.1 HSE emergency planning document

Brian Power outlined that this was an outstanding issue from the previous MAC. A HSE document 'HSE Requirements and Guidance for Outdoor Crowd Events' was included for in the meeting papers for information. After deliberation among the members it was agreed that the absence of a standard for clinical care at events is problematic. It was agreed that a standard will be developed and HSE emergency planning office should be involved in the process. It was also suggested that a stakeholder event be planned.

8. MAC Strategy 2017-2020

The members discussed the strategy of MAC for the next 3 years. To inform the strategy the following items were suggested;

- AMPDS: request printout of the top 40 calls received.

- CPC: practitioners are not getting enough access to particular interventions and there is a greater need to support them
- Set up sub-committees to explore community paramedics, critical care paramedics and clinical care at events
- CPGs: Identify what CPGs are and are not being implemented - review feedback
- Possibility of a needs analysis for ambulance practitioners.
- Treat and Referral introduction
- The Future of Paramedicine – what is PHECC's vision?

This item will need to be explored further.

9. External communications, consultation, feedback

As this MAC has not got direct representation from practitioners it was suggested that a consultative forum for RIs, CPG-approved organisations and practitioners is held twice a year and practitioners be invited. There was general consensus on this suggestion.

10. Meeting dates for the year

The Committee will meet every two months.

The following meeting dates were agreed:
Thursday 29th June
Friday 29th September
Friday 24th November
Friday 26th January

11. AOB

Cathal O'Donnell brought to the attention of the members the forthcoming retirement of Dr David McManus, former MAC member. The Committee will write to Dr McManus acknowledging his career and contribution to the Medical Advisory Committee.

Signed: _____ Date: 29.6.17.
Chair

Medical Advisory Committee

Meeting Minutes 29th June 2017

PHECC office, Naas

Present	Apologies	In attendance
David Menzies Chair	Gerard Bury	Brian Power PHECC
Shane Knox	David Irwin	Margaret Bracken PHECC
Lisa Cunningham	Ian Brennan	
Niamh Collins	Macartan Hughes	
Stanley Koe	Mark Dixon	
David Hennelly	Shane Mooney	
Hillery Collins	Cathal O'Donnell	
Martin O'Reilly	Eoghan Connolly	
Peter O'Connor	Jason van der Velde	
Mick Molloy via teleconference		

1. Chair's Business

The Chair opened the meeting and apologies were noted. Dates for meetings for the year discussed at the last meeting were agreed.

2. Minutes of previous meeting

The minutes of the meeting held on 26th May 2017 were reviewed.

Matters arising:

a) Clarification was sought on item 3.6 Clinical Practice Procedures. It was clarified that Council approved the development of a Clinical Practice Procedure manual at their last meeting and this will be discussed and developed by the PHECC Committees.

b) A concern was expressed in relation to the gender imbalance with only 2 female members on the Committee. The Chair acknowledged this and explained that nominations to the Committee were sought based on clinical expertise and nomination was the prerogative of the nomination body. It was noted that there is still one nominee open to the Chair for the Committee and the Chair is open to suggestions on this matter.

c) Item 4.1 email from a GP re Epinephrine was discussed. The Chair outlined his communications with the Wexford GP in relation to support for Epinephrine supplies. The meeting decided to follow up with advice on CPG and equipment required.

d) Item 5.2 HSE NAS Community Paramedic Project - request by HSE for PHECC to support a European Union funded project to develop a small cohort of community paramedics in Scotland, Northern Ireland and Ireland. Following discussion, it was highlighted that as pre-hospital needs in Ireland are different than Scotland and the UK. PHECC should have input and involvement in this process. Brian Power informed the members that a tender was issued in Scotland to select an appropriate

university to provide the Community paramedic education. PHECC will be in a better position to determine suitable standards and training required when the tender has been awarded. The Chair will talk to the Director of PHECC and request that this be added to the agenda for Council meeting.

Resolution: that the minutes of the Medical Advisory Committee meeting of 26th May 2017 be approved**.**

Proposed: Hillery Collins **Seconded:** Shane Knox
Carried without dissent

3. Clinical Queries

3.1 Spinal injury CPG query

Following a CPG implementation meeting between NAS and DFB two queries were sent to MAC for clarification on the Spinal Injury Management CPG. This was included in the meeting papers. David Hennelly gave an overview and a robust discussion ensued.

a) In the 'High Risk Factors' red box it was agreed to remove 'with any of the above' in relation to ≥ 65 years and ≤ 2 years on the CPG.
b) After the 'remove helmet' box the consensus was not to change the terminology of 'active and passive spinal motion restriction' to 'active and passive inline stabilisation' as changing the terminology may cause confusion.
c) It was suggested to include an arm straight to 'rule in'

Consensus could not be reached on the changes required and Brian Power was requested to re draft the CPG for consideration. Consideration will be given to a review of the EMT CPG for spinal injury management also.

As the 2017 CPGs were just published in March 2017 the implications for CPG changes at this stage was discussed. It was suggested that unless there was a patient safety issue any changes recommended would be included in a supplement issue later in the year or early next year. It was suggested that the CPG approval process be updated to include having draft CPGs in circulation with the licensed CPG providers as a proofing process. Brian Power will update the CPG approval process for discussion at a future Medical Advisory Committee meeting.

4. Correspondence

The next two items were identified with the Chair, Dr Menzies, and a short discussion on conflict of interest ensued. It was agreed that Dr Menzies would remain in the room as there was no financial conflict or personal gain involved.

4.1 Wicklow First Response re extended skills

A letter from Wicklow First Responders as included in the meeting papers for consideration. Following deliberation, it was agreed that Brian Power would write to them advising of the outcome. There was a cross over in terminology in the letter as CFR for PHECC means 'Cardiac First Response' whereas CFR means 'Community First Responders' in the letter. The letter contained three distinctive queries and also governance issues were identified. The decision in relation to the extension of skills are that they are designated at a specific clinical level and if an individual wish to perform these skills then they should be qualified at that clinical level. The decision in relation to further training by Community First Responders to enhance confidence in dealing with paediatric emergencies is that it is a matter for the individual groups and may be organised locally, however this will not be a PHECC programme. The decision in relation to oxygen therapy is to present the evidence to the Medicines Section (DoH) as soon as it is available to enable oxygen be included in the tenth schedule. From a governance perspective Co. Wicklow Community First Responders are not a licensed CPG provider and operate under the clinical governance of HSE National Ambulance Service (NAS). NAS, as the governing agency, specify the clinical standards which are authorised by its community first responders when acting on its behalf.

4.2 NTMP letter to Chair of Council re Critical Care Paramedics

Included in the papers, for information, was a letter to the chair of the PHECC Council, from the National Clinical Lead, Audit Retrieval, National Transport Medicine Programme, regarding the potential for a Critical Care Paramedic grade becoming an integral part of the retrieval service. Additional skills, education and training requirements, quality and safety issues, additional funding, and NAS staffing levels were discussed. It was agreed that Critical Care Paramedics would be scoped out.

5. Clinical Developments

There was no issue for this agenda item

6. CPG and medication updates

6.1 Medication safety in pregnancy

David Hennelly produced a medication safety matrix on behalf of NAS and DFB which was included in the meeting papers. It was agreed that this process was the appropriate may to highlight the risks for each medication during pregnancy. Brian Power outlined that this may be presented in the future field guide. The matrix to be reviewed by a pharmacist and then formally adopted by MAC.

6.2 Emergency Tracheostomy Management

A draft CPG based on the NHS Emergency Tracheostomy Management guideline was presented in the meeting papers for consideration. Following discussion there was general agreement that the CPG should be presented to a CNM expert in tracheostomy in St James's Hospital for comment and feedback.

6.3 Listed Organisations and Naloxone (Adult) CPG

The redrafted Listed Organisations and Naloxone (Adult) CPG was presented in the papers for deliberation. It was agreed to remove the reference to 'Do not touch open wounds or blood without disposable gloves'.
It was further agreed that the meeting did not require a review of the change prior to recommendation for Council.

Resolution: that CPG 1.3.6 Listed Organisations and Naloxone (Adult) be recommended to Council for approval following the change agreed.

Proposed: Shane Knox **Seconded:** Peter O'Connor
Carried without dissent

6.4 Head injury CPG

The redrafted Head Injury CPG was presented in the papers for deliberation.

Resolution: that CPG 5/6.6.5 Head Injury be recommended to Council for approval.

Proposed: Peter O'Connor **Seconded:** Shane Knox
Carried without dissent

6.5 Glycaemic Emergency CPGs

The redrafted Glycaemic Emergency - Adult CPG was presented in the papers for deliberation.

Resolution: that CPG 4/5/6.4.19 Glycaemic Emergency - Adult be recommended to Council for approval.

Proposed: David Hennelly **Seconded:** Stanley Koe

Carried without dissent
Following discussion, it was agreed that the Glycaemic Emergency - Paediatric CPG be changed to include reference to 'turn off or remove insulin pump' also. A discussion also ensued in relation to the appropriateness of Glucagon for < 1 year old. A decision was made to remove Glucagon for < 1 year old patients. It was further agreed that the meeting did not require a review of the changes prior to Council recommendation.

Resolution: that CPG 4/5/6.7.32 Glycaemic Emergency - Paediatric be recommended to Council for approval, subject to the agreed changes.

Proposed: Stanley Koe **Seconded:** David Hennelly
Carried without dissent

6.6 Behavioural Emergency CPG

The redrafted Behavioural Emergency CPG was presented in the papers for deliberation. A comment that the 'No' decision route following aggressive/violent behaviour decision was confusing. Brian Power agreed to address this by placing 'No' prior to Mental Health Illness etc. It was further agreed that the meeting did not require a review of the changes prior to Council recommendation.

Resolution: that CPG 4/5/6.4.30 Behavioural Emergency be recommended to Council for approval subject to the agreed changes.

Proposed: David Hennelly **Seconded:** Niamh Collins
Carried without dissent

6.7 Issues referred back to MAC from feedback to 2017 CPGs

Feedback on the 2017 CPGs from Niamh Collins and Gerry Bury which was referred back to MAC were included in the papers for discussion. It is noted that not all of the feedback in the papers reflected Niamh's comments. Brian Power explained that Council gave direction to publish the approved CPGs. Mick Molloy outlined the process that he conducted with the feedback to progress the publication. Some of the issues highlighted in the feedback did not refer directly to the CPGs and were considered to be training issues, some feedback could not be addressed at the time and were referred back to this new MAC.

a) **IV Paracetamol for paediatrics;** Concern was expressed about the danger of overdose from IV paracetamol administration for paediatric patients in the absence of an IV pump. Reference was made to a 2011 report in Scotland where a 13 y/o patient died following sustained and regular infusion of 1 g Paracetamol while in hospital, five doses in 24 hours. The protocol where by advanced paramedics dump the volume not required prior to hanging a paediatric infusion was outlined. It was also pointed out that only one pre-hospital dose of Paracetamol was permitted and that practitioners were required to adjust the dose downwards resulting in a maximum of 20 mg/Kg should parents/guardians have administered Paracetamol within the previous 4 hours. The issue was debated robustly, however no consensus could be reached which resulted in a vote. Brian Power sought clarification on the immediacy of this action in terms of patient safety. The consensus was that it be brought to Council at its next meeting for urgent deliberation.

Resolution: That MAC recommends to Council that IV paracetamol be removed from the Pain Management – Paediatric and Septic Shock – Paediatric CPGs in the interest of patient safety and that it be brought to Council for immediate action.

Passed by a majority (5 votes in favour; N. Collins, S. Knox, S. Koe, M. O'Reilly and P. O'Connor)

b) **Ibuprofen dose**; The maximum dose for adults is 600 mg, however the maximum dose for paediatric patients is 10 mg/Kg up to a maximum of 400 mg. If a second dose is administered for paediatric

patients, after 6 hours, it should be 7.5 mg/Kg. This has implications should parents/guardians administer Ibuprofen prior to practitioner arrival.

c) **Stridor – Paediatric**; Remove second reference to humified oxygen.

d) **Exacerbation of COPD**; There was a suggestion that PEFR has no relevance to the management of COPD. It was pointed out that PERF was a deciding factor in relation to the administration of Ipratropium Bromide. It was agreed that the CPG would be reviewed fully.

e) **Basic and Advance Life Support – Neonate (< 4 weeks);** The < 4 weeks in the title is confusing as this CPG relates to immediately following birth. It requires to be re titled and a new CPG for a neonate who arrests several hours after birth is required. Stanley Koe to work with Brian Power in redrafting same.

f) **Septic shock;** Concern was expressed about the content of the one of the available presentation IM Ceftriaxone which includes Lidocaine, due to the possibility of an accidental IV administration. A discussion ensued on the importance of fluid administration and that IV access would be available following the infusion. IO administration of Ceftriaxone was also considered, however IO access on a conscious patient was debateable. It was accepted that one of the available presentation IM administration of Ceftriaxone was required, however to minimise the risk the recommendation was not to carry the IM pack which included the Lidocaine but to carry both products separately. That way the practitioner would have to make a conscious effort to draw up for either an IV/IO route or an IM route.
The use of mean arterial pressure (MAP) on the Septic Shock CPG was discussed. It was agreed that it was no burden as it was automatically calculated on the LifePak 15 monitors which all statutory services have.

g) **Convention for units of medication**; a discussion ensued on whether the dose of Fentanyl, in particular, should be expressed in milligram (mg) or microgram (mcg). Brian Power informed the meeting that a decision from a previous MAC was to use mg for all medications, with the exception to doses in grams (g) to avoid medication error. Brian Power to check nationally on the correct convention to use.

h) **Tachycardia – Adult**; a discussion ensued on the introduction of procedural sedation for cardioversion. The meeting was informed that procedural sedation was on the agenda for future discussion.

i) **Glycaemic Emergencies**; Consideration was given to including keytone check for hyperglycaemic patients. This would involve point of care testing units. The general consensus was that it would not add any immediate value as patients who required fluids would typically have an ALoC presentation.

j) **Hypothermia EMT**; The introduction of a maximum of three shocks for severe hypothermia was suggested. A consensus could not be agreed and the CPG will be reviewed again.

k) **PV Haemorrhage in Pregnancy**; The transport location was queried. It was agreed that such patients would be transported to the most appropriate facility usually ED, but if there was a query then control could be consulted.

l) **External Haemorrhage – Paediatric**; The use of wound clips and haemostatic agents was discussed. It was agreed that both agents were appropriate for serious haemorrhage.

m) **Fluid regime**; Several CPGs have specific fluid volumes indicated. There was a call for more flexibility in relation to the fluid volumes administered. It was agreed that a pre-hospital fluid policy be developed.

n) **VF or pVT – Adult and Paediatric**; A concern was raised in relation to the title of both CPGs in so far as pVT is not a commonly used abbreviation for pulseless ventricular tachycardia. Brian Power pointed

out that pVT was used in the ILCOR Guidelines 2015 and it was adopted from there. This explanation was excepted by the meeting.

7. Clinical Practice at Events

It was brought to the meetings attention that some Community First Responder groups were providing first aid at events in their area. The risks associated with this practice were highlighted;

(i) Community First Responder groups are typically trained to Cardiac First Response level which would not give them the necessary skills to provide first aid.

(ii) Community First Responder groups linked to HSE National Ambulance Service (NAS) are indemnified by the National Clinical Indemnity scheme, provided they are tasked by NAS. It is not clear if they have their own clinical indemnity as individual groups. To practice without such indemnity is high risk. Non linked Community First Responder groups are obliged to have their own indemnity.

It was agreed that a joint letter from PHECC and CFR Ireland will be sent to CFR groups regarding clinical practice at events to highlight scope of practice and indemnity issues.

MAC to establish a subgroup to make recommendations in relation to clinical care at events. Mick Molloy agreed to chair this subgroup. Brian Power to send an e-mail to all MAC members to establish their interest in this subgroup.

8. MAC Strategy 2017-2020

8.1 Paramedic scope of practice

A draft scope of practice matrix drafted by David Hennelly was included in the meeting papers for discussion. The Education and Standards Committee are scoping out educational standards and training and will look at international models. The MAC members were requested to review before the next MAC meeting in September.

8.2 Medical Oversight for Paramedics

Medical oversight for paramedics was discussed. The question was raised should it be the responsibility of the service providers to decide on medical oversight. It was suggested to approach the service providers regarding this. The consensus was to include this on the agendas of all PHECC Committees and Council for consideration.

A suggestion was made to survey all registrants regarding the skills matrix and the level of skills used.

9. External communications, consultation, feedback

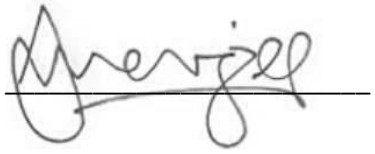
The previous MAC included representatives from the PHECC registered practitioner levels. In order to have a feedback loop with the practitioners it was suggested that a one day seminar would be held once or twice a year. To ensure interest it was suggested that key note speakers would be included and that CPC points would be awarded for attendance.

10. AOB

The Chair of the Education and Standards Committee, Shane Knox, brought to the attention of the meeting that education and training standards should be revised when CPGs are being developed and published with the CPGs. The Education and Standards Committee are revising standards at the moment.

The Chair thanked all present and the meeting concluded.

The next meeting of the Committee will be held on Friday 29th September in the new PHECC office, Beech House, Millennium Park.

Signed:  29th Sept 2017

Pre-Hospital Emergency Care Council

Comhairle Chúram Éigeandála Réamhospidéil

Medical Advisory Committee

Meeting Minutes 29/09/2017

Present:	**Apologies**
David Menzies	Shane Knox
Hillary Collins	Gerry Bury
Shane Mooney	Stanley Koe
Ian Brennan	Martin O'Reilly
Jason van der Velde	Mick Molloy
Macartan Hughes	Mark Dixon
Eoghan Connolly	
Niamh Collins	**In Attendance**
Peter O'Connor	Brian Power
David Irwin	Deirdre Borland
Cathal O'Donnell	

1. **Chairs Business**
   The Chair welcomed the assembled members and apologies were noted.
   The Chair indicated that a letter will be send to Community First Responder groups regarding clinical care at events, the Chair requested that the final decision in relation to this matter be made jointly by himself and Brian Power, this was agreed by all without a resolution.

2. Minutes from June meeting
   Minutes from the Medical Advisory Committee held June 2017 were included in the meeting papers for the Committees approval. Niamh Collins identified a number of typographic errors, which were noted. It was also noted that to add more clarity to the discussion "one of the available presentations" needs to be inserted prior to 'IM Ceftriaxone'.

   Resolution: That the minutes of the Medical Advisory Group be approved subject to the above amendments.
   Proposed: Hillary Collins Seconded Shane Mooney
   Carried without dissent.

   2.1 Matters Arising

   Niamh Collins asked that the committee consider if circulating CPGs to service providers for feedback needs thought and consultation as this could lead to considerable requests for change following final deliberations. Shane Mooney outlined that the practitioners would

be requested to review the CPGs from a practical view point in that the algorithm worked in practice.

Jason van der Velde proposed that the clarity be given regarding terminology use regarding differentiating various Community Paramedic Pilot Schemes and the separate PHECC Community Paramedic Strategy.

Resolution: That the Medical Advisory Committee recommends to Council that in written documentation, PHECC will use the term Community Paramedic Strategy to avoid confusion with various Community Paramedic Pilot Schemes.

Proposed: Jason van der Velde Seconded Niamh Collins

Carried without dissent

Following on from this point The Chair asked the committee to give consideration to the potential for any licensed CPG provider to operate outside PHECC CPGs and the implication thereof.

It was expressed that a safety mechanism could be put in place should any organisations want to work outside PHECC CPGs.

It should be made clear that the responsibility lies directly with the medical director of the licensed CPG provider if he/she privileges practitioners to operate outside their scope of practice. A discussion took place regarding risk of fitness to practice implications for practitioner operating is such circumstances.

Brian Power informed the committee that PHECCs approval to implement CPGs was a voluntary process for all except the HSE National Ambulance Service. Under the Health Act 1970 Section 57 (2) 'In making arrangements under this section [*provision of an ambulance service*], a health board shall act in accordance with the direction of the Minister'. PHECC standards are the 'direction of the Minister'. A discussion ensued as to whether PHECC standards were a minimum. Brian Power advised the committee that although the PHECC legislation is weak, if an organisation wished to be approved by PHECC then they are obliged to abide by Council rules.

Jason van der Velde asked if this is an issue to be referred to the Quality and Safety Committee.

Shane Mooney asked if a list could be provided to Council or the Quality and Safety committee of licensed CPG providers who have asked for permission to be exempted or of additional interventions outside the scope of practice. Brian Power informed the committee that requests for exemptions are currently a part of the CPG approval process (POL003). He further informed the committee that there were no requirements, under current Council rules, for licensed CPG providers to inform PHECC when they introduced interventions outside the PHECC scope of practice. He advised that he had informal discussions with a small number of private licensed CPG providers in relation to the operation of TR bands post angioplasty.

Caution was expressed as to the level of information that should be sought from organisations wishing to permit care under the direction of a medical director outside the PHECC standards.

Resolution: That the Medical Advisory Committee recommend to Council to add a declaration of supplementary interventions as a condition of approval for licensed CPG providers in POL003.
Proposed Peter O Connor Seconded Dave Irwin
Carried without dissent

The Behavioural Emergency CPG was returned by Council to MAC for further consideration. Jason van der Velde committed to provide recent information pertinent to this CPG from the telemedicine centre in CUH to the MAC for consideration at the next meeting.

Brian Power informed the committee that due to staffing resources within PHECC it is no longer feasible to host meetings on Fridays. It was agreed to proceed with 24th November as the next meeting date as it was scheduled. From January the Committee will revert to the last Thursday of every second month (January 25th, March 29th, May 31st, July 26th, Sept 27th and Nov 29th).

2.2 External Communications, consultation, feedback.

Discussion arose regarding the proposed event to keep practitioners informed of MAC developments. A debate ensued as to whether it could be incorporated into the same day as a MAC meeting. It was agreed that there could be considerable interest and to have a limited engagement with practitioners would be counter-productive. Due to budget limitations in 2017 Brian Power suggested that February 2018 would be an appropriate timeframe. The Chair and Brian Power to develop a programme for same.

3. Clinical Queries

3.1 T-piece

A query was received from a practitioner regarding the introduction of a T piece to facilitate nebulising a patient experiencing life threatening asthma and has become exhausted. Niamh Collins outlined the difficulties with a nebuliser if the device is not upright and recommended the use of an accordion device such as an Armstrong Medical Spiral or similar. It was asked if there are any statistics of occurrences where a T piece may be of benefit. It was suggested that widening the indications for CPAP may be an answer.

It was highlighted that CPGs do not rule out the use of a C circuit, however this was an issue for individual services to consider. A suggested solution is to administer IM Epinephrine as a bronchodilator by paramedics and advanced paramedics eliminating the need to introduce additional equipment. Hillary Collins and Jason van der Velde agreed to review the literature on IM Epinephrine in this clinical setting and revert back to the Committee.
If the evidence merits this intervention a redrafted COPD or Asthma CPG will be brought to a future meeting.

4. Correspondence

There were no items for this agenda item

5. Clinical Developments

5.1 Convention for medication dose weights.

Following from a query in relation to the convention for medication does weights Muriel Pate Chief Pharmacist from Naas Hospital provided guidance to MAC with regard to the national convention which was included in the meeting papers. She advised changing the PHECC convention for medication dose weight from mg to microgram (mcg) where the dose was less than 1 mg in line with HSE guidelines. It was agreed that the MAC should follow these guidelines. Brian Power informed the Committee that this would have implications for a wide range of CPGs and the PHECC field guide. Concerns were expressed about patient safety during the change over from mg to mcg. Brian Power advised that this could not be done immediately as the CPGs would have to be changed and practitioners would have to be notified. It was suggested that as a number of CPGs are being amended currently that an issue date be agreed and the medication convention change be made simultaneously.
It was asked that consideration be given to age ranges and use uniformity regarding age grouping and ≤ and ≥ when amending paediatric CPGs.

Resolution:
That MAC recommends that Council approves the PHECC convention for medication dose to be changed to specify micrograms (mcg) when referring to medication doses less than 1 mg. This convention to be changed in a co-ordinated way with the stakeholders involved.

Proposed: Dave Hennelly Seconded: Niamh Collins
Carried without dissent

The lack of a field guide to reflect the current CPGs was highlight as a matter that needed prompt resolution. Brian Power informed the Committee that it was hoped that resources will be in place to progress the electronic field guide within the coming weeks.

The example of the Great North Air Ambulance field guide which presented its document on an age per page basis was mooted as an example of how future iterations of the PHECC Field guide be presented. Brian Power informed the Committee that this would involve a considerable change to layout of the current field guide and would involve significant resources to proceed in this manner.

Resolution:
That the Medical Advisory Committee recommend to Council that future editions of the Field Guide would be amended to an age per page presentation for medication calculations.

Proposed: Dave Irwin Seconded: Cathal O'Donnell
Carried without dissent.

6. CPG Development Process
   6.1 IV Paracetamol for paediatrics

The Council in its deliberations has requested MAC to reconsider the issue of administration of IV paracetamol with the absence of an IV Pump in light of the very tight vote on the matter at MAC. The Chair noted that there was division between members at the last meeting regarding this subject and there were a number of members absent today,

including the MAC's Paediatric specialist. A discussion ensued regarding progressing the issues, the work of the committee and the implications of member presence/absences at meetings. Members present indicated that they were happy to proceed with discussing this item.

Niamh Collins indicated that she considered there is a risk that a child would get too much or too fast a dose of IV Paracetamol in the absence of a pump delivery system being used. She also indicated that her concern lies with the speed of administration of IV Paracetamol and the potential harm caused if the medication is given too quickly.

A lengthy discussion ensued regarding the need for IV paracetamol when other medicinal options were available. The following issues were expressed by the various members present;

- Caution that there may be a tendency to give opiates where Paracetamol is available which is often a more appropriate first option for analgesia.
- That there was an antidote available in the case of opiate overdose but the risk of liver damage from inappropriate Paracetamol administration could lead to catastrophic liver damage.
- Where PO administration of medications was not possible IN Fentanyl was an option.
- That for a child with traumatic injuries and reduced blood pressure both Fentanyl and Morphine are contraindicated therefore IV Paracetamol is the only option for severe pain.
- Consideration be given to dose for adult patients with low body mass when administrating IV Paracetamol.

Jason van der Velde indicated that he would strongly support the retention of IV Paracetamol as his pre-hospital experience has led to minimal opiate analgesia when IV Paracetamol is used.

David Irwin questioned why potential overdose was being discussed, he suggested that practitioners are trusted to administer a wide range of medications and their competence allows them to conduct medication calculations in a safe manner. This was strongly supported by Shane Mooney.

Cathal O'Donnell informed the committee that he has no concerns regarding the ability of practitioners to administer medications safely and appropriately. He indicated that there is a PHECC KPI for pain management and he is happy to circulate this data to the Committee as it comes available.

Jason van der Velde informed the meeting that the use of glass bottles in the prehospital setting can easily result in air embolus and strongly recommended that plastic containers should only be utilised.

It was agreed that there will be a Delphi process undertaken on IV Paracetamol for paediatric patients focused around five sub-headings.

a) There is no requirement for IV Paracetamol in light of other medications available for analgesia.
b) In the absence of a pump or buretrol system the speed of administration of IV Paracetamol is a high risk.

c) In light of the 1 g or 500 mg containers for IV Paracetamol there is a high risk of an overdose situation for lower dose requirements.
d) There is a strong risk of an air embolus during IV Paracetamol administration.
e) Toxicity following IV Paracetamol administration is high risk.

6.2 Spinal Injury Management

Following direction from the last meeting draft Spinal Injury Management CPGs and updated position paper were included in the papers for the committee's review.

Niamh Collins expressed a fundamental concern regarding the structure of the Spinal Injury Management CPGs as presented and the assessment of high risk factors and subsequent treatment pathway. She stressed that mechanism of injury is a key component of the decision making process for the management of spinal injury.

The Chair expressed a concern about a fundamental concern being raised at this late stage of the drafting process. Niamh Collins stressed that she has continually made her position clear with regard to this issue at all stages of the development of this CPG.

Resolution: That MAC agree to undertake the process of amending the spinal injury CPGs and position paper at today's meeting in order to present them for the next Council meeting.
Proposed: Shane Mooney Seconded: Peter O'Connor
Carried without dissent

A discussion ensued and a number of amendments were suggested to the draft CPG. The current CPG for P and AP, version 3.3 be amended as follows;

- After remove helmet insert 'Assess risk factors' leading to high or low risk factors.
- Remove reference to 'manual' in active spinal motion restriction.
- Change all terminology to reflect either 'active spinal motion restriction' or 'passive spinal motion restriction' throughout the CPG for consistency.
- Over low risk factors to include a heading; 'Unlikely to have a clinically significant spinal injury'.

A break was called and the CPG was amended with the suggested edits and presented to the committee for consideration.

Resolution: That MAC recommend to Council the approval of Spinal Injury Management CPG (5/6.6.9) as presented with the changes outlined above and that the corresponding changes be made to the Spinal Injury Management Position paper (STN024).

Proposed: Eoghan Connolly Seconded: Dave Hennelly
Carried without dissent

Resolution That MAC recommend to Council the approval of Spinal Injury Management CPG (4.6.9) with the changes as outlined above.

Proposed: Peter O'Connor Seconded Eoghan Connolly
Carried without dissent.

Resolution: That MAC recommend to Council the approval of Spinal Injury Management CPG (2/3.6.9) with the changes as outlined above.
Proposed: David Irwin Seconded Hillary

In light of the two month gap between MAC meetings and the urgency to address the spinal injury management CPGs a number of Council members on the Committee asked that it be agreed that the recording of the above resolutions in relation to spinal injury management be approved now rather than waiting until the minutes are viewed at the next meeting.

Resolution: That the minutes of the recording of the resolutions regarding the approval of the spinal injury management CPGs and position paper be approved.

Proposed: Hillary Collins Seconded*: (i) Jason Van Der Veld (ii) Shane Mooney
Carried without dissent **note all Council members present wished to support this resolution*

6.3 Emergency Tracheostomy Management

Ms Orla McKenna, A CNS tutor with specialism in the care of tracheostomy patients from St James Hospital has provided guidance to the MAC on the care of patients with tracheostomy or laryngectomy. Jason van der Velde, indicated that guidance from staff in CUH agreed with Ms McKenna's guidance, it was noted however that the care of a tracheostomy patient in hospital by experienced staff will differ due to the low-level exposure that PHECC practitioners will have in the pre-hospital scenario. It was pointed out that such encounters were typically an acute emergency for PHECC practitioners. A discussion ensued regarding the availability of humidified oxygen. It was stated that this was unlikely to be available in the pre-hospital setting, however a nebuliser could be used with NaCl if required.

It was agreed that this CPG should also include EMT level. It was pointed out that commencing CPR for a non-breathing patient with a pulse was not required. Following discussion, it was agreed to remove all the 'commence CPR' boxes from their current location and place one above 'consider intubation'. It was agreed to add 'if no pulse present' to this box. In the 'consider intubation' box if was agreed to delete '6 mm' and add '(use smaller ET tube than normal)'

6.4 COPD Exacerbation

CPG 4/5/6.3.3 Exacerbation of COPD was included in the meeting papers for review. It was suggested to move Ipratropium Bromide to immediately after Salbutamol. Niamh Collins asked that the role of CPAP in COPD be reviewed, she volunteered to undertake a literature review and share with the group. As discussed earlier it may be appropriate to introduce IM Epinephrine to a COPD patient that requires bronchodilation but is too exhausted for effective nebulisation use.

7. Clinical Care at Events

The chair thanked the members who volunteered to contribute to this subgroup and welcomed their future insight to this important area of pre-hospital care.

Brian Power informed the Committee that Dave O'Sullivan, Chief Emergency Planning Officer, HSE South has made contact with the Chair of Council in relation to this matter and suggest that he be invited to join the sub group. He also suggested that representatives from the licensed CPG providers that have experience with events be invited to join the sub group. The Chair suggested that the sub group have an initial meeting and invite others to contribute as necessary.
Ian Brennan's name was added to the list of MAC members who will form the sub group.

Cathal O'Donnell asked that the terms of reference examine the legal contexts around medical cover at events and the roll of statutory ambulance services. He also asked that the issue of non licensed CPG providers who are providing clinical cover at events be considered.

Jason van der Velde asked that the inclusion of specified clinical competencies be included in the terms of reference and remove reference to PHECC clinical levels.

Brian Power asked what administrative support would be required for the sub group. It was agreed that he will attend the meetings together with a clerical support officer.

Resolution: that the Terms of Reference of the Clinical Care at Events sub group be approved subject to the inclusion of the above items.

Proposed: Peter O'Connor Seconded: Macartan Hughes
Carried without dissent.

8. MAC Strategy 2017 – 2020

The Chair asked that the MAC review the future requirements for paramedic practice. Cathal O'Donnell asked that PHECC engage with the HSE National Ambulance Service, Dr Áine Carroll from the HSE clinical programmes office and the Department of Health in relation to the future developments within the health sector that might imping on paramedic practice. It was also suggested that the PHECC registrants are consulted also.

Dave Hennelly asked that as the medical expert group of PHECC, that the MAC scope their own development.

9. External communications, consultation, feedback

9.1 Email from Dr Beecham re CPGs feedback.

An email from Dr Gabriel Beecham, Specialist Anaesthesia trainee, Mater Hospital was included in the meeting papers. Dr Beecham voiced a number of suggestion regarding clinical elements concerning PHECC CPGs.

9.1.1 Glasgow Coma scale; noting a new and updated structure. Dave Irwin gave an overview of the updates in the Glasgow Coma Scales by the Institute of Neurological Sciences. This will involve a change of wording to the GCS and will require PHECC to amend the PCR, ACR and selected CPGs.

Resolution: That the Medical Advisory approve the amendment of any CPGs, the PHECC Patient Care Report and Ambulatory Care Report to reflect the changes in the updated Glasgow Coma Scale.

Proposed: Eoghan Connolly Seconded: Dave Hennelly.

Carried without dissent

9.1.2 PV Haemorrhage in Pregnancy

Dr Beecham suggested that the time frame for the left lateral tile in PV Haemorrhage of 24 weeks gestation should be changed to 20 weeks in light of AHA's scientific statement on resuscitation in pregnancy (2015). It was agreed to consider this under the next scheduled review cycle for CPG 4/5/6.6.5.3.

9.1.3 Medication Formulary

Dr. Beecham asked that the MAC consider that that 'pupil dilation' and 'transient bradycardia' listed as side effects be removed from the Glycopyrronium Bromide formulary as this is not the case.

Resolution: That the Medical Advisory Committee approved the removal of 'pupil dilation' and 'transient bradycardia' as a side effect of Glycopyrronium Bromide in the AP Medication Formulary for the next edition of same.

Proposed: Eoghan Connolly Seconded: Shane Mooney

Carried without dissent

9.1.4 Rapid infusion of Paracetamol may lead to reduced blood pressure. This item was discussed earlier and no further discussion took place on it.

Dr Beecham to be written to and thanked for his submission to the MAC.

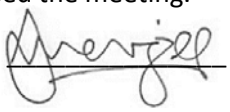
10. AOB.

Shane Mooney asked when the Verification of death form will be made available to the services. Brian Power informed the committee that a form has been printed in booklet form and that he would send Shane a booklet and advise where he can get additional copies printed.

The Chair stated that submissions of agenda items must be made prior to meeting papers being distributed. Brian Power informed the committee that at least two weeks prior to a meeting was required to ensure inclusion in the papers.

The next MAC Meeting will be held on 24th November at 10:00 in the PHECC office, Naas.

There being no other business the Chair thanked the members present for their contribution and closed the meeting.

Signed:  Date: 24th Nov 2017

Pre-Hospital Emergency Care Council

Medical Advisory Group

Meeting Minutes

24th November 2017

Present
David Menzies (Chair)
Martin O'Reilly
Jason Van der Velde
Peter O'Connor
Macartan Hughes
Niamh Collins
Shane Knox
Mark Dixon
Lisa Cunningham
Dave Irwin
Mick Molloy
Gerry Bury
Shane Mooney
Stanley Koe

Apologies
Ian Brennan
Cathal O'Donnell

In attendance
Brian Power
Deirdre Borland

1. Chair's Business

The Chair welcomed the assembled members to the meeting. Apologies were noted.

2. Minutes from September 2017 meeting.

Draft meeting minutes from the September 2017 MAC meeting were included in the meeting papers for review and approval.

Resolution: That the Medical Advisory Committee approve the meeting minutes of September 29th, 2017.
Proposed: Peter O'Connor **Seconded:** Dave Irwin
Carried without dissent

2.1 Matters arising

The matter of seeking notification of additional interventions sanctioned by medical director's authority was raised, caution was expressed as to the interpretation of SI 300 of 2014 and MAC's remit and responsibility regarding acting of such information.

A discussion ensued regarding the risks of SI 300 of 2014 and the challenge of maintaining the uniformity of service provision.

The Chair indicated that there was currently a knowledge vacuum as to what is happening in practice, and by seeking prior notification of such instances the MAC can formulate a strategy to safeguard the integrity of the CPGs.

2.1.1 Acute Frailty Programme

Following a discussion, it was suggested to contact the Acute Frailty Programme, who are developing Community Advanced Nurse Practitioners, in order to establish any parallels with the Community Paramedic Pilot.

3. Clinical Queries

3.1 CPG 5/6.5.2 Basic & Advanced Life Support – Neonate (< 4 weeks)

It was noted that the CPG indicated consider Supplemental 0_2 (≤30%), however there is no method of delivering 0_2 ≤30% available to practitioners. Stanley Koe suggested that this may be removed and resuscitation by air was a suitable alternative. Brian Power to write to NNRP to bring the response back to the committee.

3.2 Medication Formulary Ketamine

Resolution: In the Medication Formulary for Ketamine remove raised intracranial pressure as a contraindication

Proposed: Jason Van der Velde **Seconded:** Macartan Hughes

Carried without dissent

3.3 Double Sequential Defibrillation

A discussion ensued on the benefits and appropriateness of double sequential defibrillation (DSD). Gerry Bury informed the committee that he has been made aware by a manufacturer of ECG monitor/ defibrillators been burned out due to quirk in the electronics when used for DSD. The committee were informed that requests have been received by medical support services at CUH for authorisation for DSD. It was agreed that medical support at CUH should not recommend Double Sequential Defibrillation. It was suggested that organisations be contacted via a patient safety notice to notify them that double sequential defibrillation is not currently indicated on any CPG and as such should not be attempted.

Resolution: That the MAC circulate a patient safety notice to all licensed CPG providers regarding the practice of Double Sequential Defibrillation.

Proposed: Peter O'Connor **Seconded:** Eoghan Connolly.

Carried without dissent

3.4 Tranexamic Acid

Clarification was sought as to the suitability of Tranexamic Acid to paediatric patients. Stanley Koe indicated that there is no contraindication to the administration of Tranexamic to paediatric patients. Max dose of 1 gm was indicated.

3.5 Cease resuscitation EMTs

A query regarding a discrepancy regarding the ability of an EMT and Paramedic to cease resuscitation was discussed. It was agreed that the list of exceptions for ceasing resuscitation as per paramedic CPGs be included in the relevant EMT CPGs.

3.6 Midazolam

A practitioner query regarding the timings of repeat doses of midazolam was discussed. It was agreed that this was primarily a matter of clinical judgement and education however an inclusion of a repeat timing direction should be given. Stanley Koe will research and report back to the committee.

3.7 Morphine administration after Fentanyl

Clarification was sought regarding CPG Pain 4/5/6.2.6 Pain Management, which currently inhibits the administration of Morphine after a second dose of Fentanyl. This was raised as a potential issue, particularly for patients with long transfer times. Further discussion is needed prior to making a decision on this matter.

3.8 Paediatric Primary Trauma Survey

It was brought to the committee's attention that on the Paediatric Primary Survey – Trauma CPG a jaw trust is defined as head tilt chin lift. It was agreed that this should be immediately rectified.

It was requested that a definitive list of all amendments to current CPGs since they were published be made available.

The Chair stressed that no new CPGs will be created or amended unless a specific and immediate patient safety concern is identified.

3.9 Adenosine

A discrepancy between the heart rates indicated on CPG 5/6.1.12 Tachycardia – Adult and the Medication formulary (150 v 180) was identified. It was also agreed that Wolf Parkinson White be included as a contraindication for Adenosine.

The maximum dose of 30 mg was queried. It was noted that the current edition of the ILCOR guidelines recommends 6 mg initially and 12 mg for repeat doses.

3.10 Amiodarone

It was noted that Polymorphic VT should not be included in the medication formulary for Amiodarone. It agreed that Magnesium Sulphate for torsade du pointe be maintained.

3.11 Tachycardia CPG

The visual presentation of the CPG 5/6.1.12 Tachycardia – Adult was discussed, it was suggested to simplify it into separate rhythm streams. It was agreed to defer this to the next edition of the CPGs.

Discussion ensued regarding adverse signs arm of the CPG. There was a possibility that the CPG could lead to the practitioner administering Amiodarone to a patient with AFib. It was agreed that upon identification of AFib to seek medical support.

Resolution: Insert an advisory box indicating 'If AFib seek medical support' after NaCl and before consider Amiodarone on CPG 5/6.4.12 Tachycardia - Adult.
Proposed: Dave Irwin **Seconded:** Peter O'Connor
Carried without dissent
As this was regarded as an urgent update a further resolution was made to include this CPG in the next Council's papers for approval.

Resolution: The minutes of the above resolution be passes and the necessary amendments be actioned for Council.
Carried without dissent

Proposed: Shane Mooney **Seconded:** Shane Knox
Carried without dissent

3.12 Paediatric dose age standardisation

Following discussion, it was agreed that a convention be adopted when referring to paediatric age to reduce any confusion. All ages be written as ≤ (less than or equal to) or ≥ (greater than or equal to) in reference to age for medications in all paediatric CPGs. It was agreed to defer implementing this change until the next edition of the CPGs.

5. Clinical Developments

5.1 Patient Care Report Information Standard 2017

Jacqueline Egan gave an overview of amendments to the PCR information standard reflecting updated practice and policies.

The following suggestions will be considered and the draft standard amended accordingly. A brief discussion ensued regarding the ownership of data and the use of the clinical data.

A further draft will be presented at a future meeting.

a) free text fields be maintained
b) Section 5.2 Include time definition
c) Amend PCR left on scene to include name of person form handed over to to whom the IDS was.
d) The option to allow clinical examination to be incorporated with the additional information section.
e) Change severe sepsis to Sepsis box to Severe/Septic Shock. Check for preapproval
f) For point 7.3 Include "other"
g) 7.2 Remove active cooling include Contact PCI
h) 7.7 remove "contacted"
i) 16.6.1 merge "nurse" with other professions listed
j) A need to capture multiple re arrest/ROSC was voiced
k) 12.9 Change to ROSC at ED

l) Clinical Oversight contacted field required, medical direction outside CPGS needs to be captured
m) 9.3 and 9.4 capture clinical lead inc MD
n) 12.3.1. Capture if dispatcher assisted
o) 12.6 Shock – AED Shock Advised. Include NA option. Was shock delivered removed not shock advised.
p) 1.7 Include Healthcare facility option
q) 1.1 replicate wording to 1.2 – 1.3.

5.2 P/AP recognition of heart block and transcutaneous pacing

This item will revert to a future meeting.

6. CPG Development Process

6.1 Pain Management CPG – IV Paracetamol for paediatrics

Council asked MAC to have further consideration regarding the exclusion of IV Paracetamol for paediatrics on the Pain Management – Paediatric CPG. The Irish Medication and Safety Network (IMSN) were contacted as directed, however their response came too late for inclusion in the papers and was tabled at the meeting. IMSN advised that the safety alert was written with reference to hospital administration of Paracetamol and gave no further advice. They did suggest that Ms Laura Byrne from Our Lady's Children's Hospital would be happy to engage with specific paediatric queries. It was suggested that contact be made with Ms Byrne in relation to this issue.

A Delphi was circulated to all members in advance of the meeting asking for opinion on the following statements;

a) There is no requirement for IV Paracetamol in light of other medications available for analgesia.

b) In the absence of a pump or buretrol system the speed of administration of IV Paracetamol is a high risk.

c) In light of the 1 g or 500 mg containers for IV Paracetamol there is a high risk of an overdose situation for lower dose requirements.

d) There is a strong risk of an air embolus during IV Paracetamol administration

e) Toxicity following IV Paracetamol administration is high risk.

Stanley Koe indicated that on balance Paracetamol is a low risk medication, however the consequences of inappropriate administration can be severe. He stressed like as with all medications need to be administered correctly and appropriately.

Niamh Collins reiterated her belief that in the light of multiple safety notices regarding IV Paracetamol for paediatric patients she strongly objected to maintaining its inclusion in the Paediatric Pain Management CPG.

There followed sustained and rigorous debate on the matter.

The Chair thanked all members for their valuable contribution to the debate. It was suggested that "administer slowly over 15mins" be included in the Mediation Formulary and a clinical skills module be developed. If new evidence becomes available the committee will revisit this matter.

Resolution: That MAC recommends no change from the existing paediatric Pain Management and Septic shock CPGs in relation to IV Paracetamol.

Proposed: Shane Mooney **Seconded**: Dave Irwin

Following a vote: 10 in favour, 2 against and one abstained.

Resolution: that the Medication formulary for IV Paracetamol be amended to include "Caution with IV Paracetamol in the absence of a buretrol" and "Administer slowly over 15 mins"

Proposed: Shane Mooney **Seconded:** Jason Van der Velde

Carried without dissent

6.2 Emergency tracheostomy management

Draft CPG 4/5/6.x.y Emergency tracheostomy management was included in the meeting papers for the committees review. The following amendments were requested;

a) ETCO2, if available - remove "a positive reading indicated a patent or partially patent airway.
b) Insert consider saline neb after applying high flow O_2 to both face and neck

6.3 COPD CPG

Niamh Collins undertook a review of research papers regarding COPD and gave an account of her findings to the committee. A draft CPG Exacerbation of COPD was included in the meeting papers. The value of CPAP for both asthma and COPD were considered, as was the merit on IM Epinephrine. It was agreed to revisit this at a future meeting.

6.4 Behavioural Emergency CPG

Jason Van der Velde presented a breakdown of calls to the medico service in Cork. The information was too late for inclusion in the meeting papers and was tabled on the day. He highlighted behavioural emergencies and Traumatic Brain Injury as providing a high volume of their calls. He asked that the committee consider a review of the behavioural emergency CPG. The Chair asked that the work be scoped for developing the CPG. Dave Irwin, Jason Van der Velde and Lisa Cunningham will meet to progress this work.

6.5 Stridor

Draft Stridor – Paediatric CPG was included in the meeting papers for consideration.

Resolution: That the Medical Advisory Committee recommend to Council CPG 4/5/6.7.13 Stridor – Paediatric for approval.

Proposed: Mick Molloy **Seconded:** Peter O'Connor

Carried without dissent

7. Clinical Practice at Events

7.1 Clinical Care at Events Sub group

This item will revert to a future meeting.

8. MAC Strategy 2017-2020

This item will revert to a future meeting.

9. External communications, consultation, feedback

No items were raised.

10. AOB

The future of transporting patients to Minor Injury units was raised. PHECC has submitted a proposal to the Emergency Medicine Programme (EMP) regarding this project. It was agreed to bring this proposal back to a future meeting for further discussion.

Signed: _____ Date: 25.1.18.