Medical Advisory Committee
Meeting Minutes
27th June 2019, PHECC office @ 10:00am

Present
David Menzies (Chair)
Philip Darcy
Ian Brennan
Martin O'Reilly
Eoghan Connolly
Niamh Collins
Peter O'Connor
Stanley Koe
Jason van der Velde
Lisa Cunningham Guthrie
Gerard Bury

Teleconference:
Hillery Collins
David Hennelly
Mick Molloy

Apologies
David Irwin (Vice Chair)
Shane Mooney
Macartan Hughes
Mark Dixon
Shane Knox
Cathal O'Donnell

In attendance
Richard Lodge, PHECC Director
Brian Power, PHECC PDO
Ricky Ellis, PHECC PDO
Margaret Bracken, PHECC Committee Officer
Dympna Higgins, PHECC Support Officer (agenda item 7.1 only)

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1. Chair's Business

The Chair welcomed the members. Apologies were noted.

2. Minutes from April 2019 meeting

The minutes of the meeting held on 30th May were reviewed and agreed by the members.

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 30th May 2019.

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

2.1 Matters arising

The Chair reported that Council are advancing with the PHECC Strategy 2019-2021. At the May 2018 MAC meeting members identified three main priorities from a list for the MAC strategy; Community Paramedic, Critical Care Paramedic, Treat and Refer. It was agreed that the remaining items on the list will form part of the Council Strategy. It was agreed not to develop multiple new CPGs, but rather to concentrate on refining existing CPGs and developing the evidence base for these further. The Chair asked the Director whether the development of new CPGs would be included in the Council Strategy. The Director stated that he will discuss with Council the possibility of inclusion in the next Council strategy as the current strategy is near

completion. He suggested that a clinical document could be drafted and submitted to Council, which will provide the MAC with a remit to continue with the development of new CPGs as necessary.

3. Clinical Queries

There were no clinical queries for discussion.

4. Correspondence

4.1 Delaying defibrillation for cardiac arrest subset

4.2 Expanded utilisation of waveform capnography and compressions during defibrillator charging

4.3 Apnoeic Oxygenation

4.4 Active Compression Decompression + ITD

4.5 Heads up CPR

4.6 Pre-hospital treatment of hyperkalaemia

4.7 Midazolam IM for EMTs

The large volume of practitioner correspondence in the meeting papers was noted. The Chair thanked the practitioners for their correspondence noting the importance of their input to the MAC. He registered concern that, due to full agendas for MAC meetings, there may not be adequate time available to discuss all of the correspondence. He suggested, going forward, if there is an increasing volume of correspondence it might be necessary to put a structured process in place. Eoghan Connolly informed the meeting that he advised the registrants to write and submit the correspondence contained in the meeting papers, and the registrants have put a lot of work into drafting the material for consideration of the MAC.

The members concurred that practitioner engagement is very important and is to be encouraged. It was suggested to hold a day event around the country in the Autumn and invite practitioner engagement and feedback. It was agreed that the practitioner correspondence contained in the meeting papers will be helpful when reviewing the next set of ILCOR guidelines. David Hennelly proposed developing a structured process for clinical change suggestions and practitioner feedback. He agreed to draft a submission form with Brian Power for consideration of the Committee.

5. MAC Strategy 2017-2020

5.1 Pre-hospital emergency care practice definitions for Ireland

At the May MAC meeting some amendments were agreed to the draft document 'Pre-hospital emergency care practice for Ireland'. Revised and amended draft document was included in the meeting papers. The Chair provided an overview reiterating the concerns expressed by Cathal O'Donnell at the May meeting as to the purpose of the document. A discussion ensued. It was advised that, as the regulator, PHECC's role is to set standards. The Chair stated that the draft document when finalised will be recommended to Council for approval and will be recommended to the Quality and Safety Committee to develop a standard thereafter.

* Gerard Bury joined the meeting.

Triple Lock (privileging), and the availability of equipment and medications for the provision of clinical care, was discussed. It was agreed to reinforce the triple lock and add this to the Introduction as a separate paragraph. It was noted, as stated in 'Council Rules for pre-hospital emergency care service providers who apply for approval for implementation of Clinical Practice Guidelines (CPGs)' that 'the medications and equipment for the administration of pre hospital emergency care, available when providing a pre-hospital emergency care service, are appropriate to the clinical levels as outlined in the current PHECC Medications & Skills matrix.'

It was advised that it is within PHECC's remit to regulate, determine or limit those practitioners they are responsible for and PHECC can define pre-hospital emergency care only for those that are being regulated by PHECC. It was stated that the document needs to be clear who is being advised. Jason van der Velde provided some background explaining that following the death of a fighter after an MMA fight in Dublin in April 2016 it was agreed that a document defining clinical care at events was needed. Professor Bury advised that it should clearly state if this is a discussion document or an information document, and he suggested circulating the document for wider consultation. The Director stated that it is a discussion document which will be developed as a standard following Council approval.

The pre-hospital emergency care definition as stated in the document; 'Responders are co-certified by PHECC and an approved training institution' was referenced and clarification sought on the meaning of co-certified in this context. Brian Power clarified that certificates are issued from the approved training institution (ATI) and they include the ATI logo and the PHECC logo. It was stated that this should be made clear in the document and it was queried who certifies dispatchers. Brian clarified that both DFB and NAS provide training for dispatchers using the PHECC course content, however neither issue the PHECC certificates. The importance of accountability and competency from a public point of view was highlighted. It was agreed that Brian Power will add a paragraph on accountability to the document under 'Clinical Scope'.

The different levels of clinical care was discussed. It was remarked that the different clinical care levels can be confusing for the public. It was noted that the clinical care levels are set out in the CPGs. It was advised that 'paramedic' needs to be clearly defined as the public are not aware what a paramedic is. It was noted that PHECC practitioners are interacting on a daily basis with practitioners from other regulatory bodies and this can be very challenging for the practitioners. Professor Bury stated that a whole spectrum of clinicians could be added to 'Clinical Scope' between ALS and CCS and he suggested that a definition for doctors be included. It was suggested that the definition for treat and refer be included.

Professor Bury stressed that the role of PHECC is to 'protect the public' and he suggested the document be considered as an advocacy document and be circulated for consultation and exploration at a wider level before being developed as a standard.

Following discussion the members agreed the following amendments to the document 'Pre-hospital emergency care practice definitions for Ireland'.

1. Purpose

Replace the word 'define' with 'describe';

'This document aims to describe pre-hospital emergency care pre-hospital clinical levels of care and nomenclature in Ireland.'

2. Introduction

To be divided into three paragraphs as follows:

Paragraph 1:
Replace the word 'define' with 'describe';
'A well governed pre-hospital emergency care system needs to clearly define the clinical level of care it provides at a given point in time.'

Paragraph 2:
Replace the word 'define' with 'describe'
'A range of registered practitioners and community-based responders currently respond to pre-hospital emergencies in Ireland. They bring welcome, but vastly varying levels of competence, clinical decision making, equipment and medications to the scene. From a clinical governance and operational control perspective, it has become essential to develop a framework to clearly describe the clinical level of care an individual resource can deliver at a given point in time.'

Paragraph 3: move down from paragraph 1 and amend to read as follows:
'The clinical level of care being delivered to a patient is far more complex than simply the training of an individual practitioner or responder. It importantly incorporates their;

- Credentialing - registration with a recognised professional body (where applicable) or certified as a responder
- Licencing – clear clinical governance within the employing/ voluntary body
- Privileging – working within their agreed scope of practice, and
- coupled with the equipment and medications immediately available to provide a defined clinical level of care.'

3. Pre-hospital emergency care definition

(1) PHECC Practitioners

- Second sentence: add 'clinical decision making' and delete 'prescription only (POMs) as specified on the Seventh Schedule' to read;
'The PHECC practitioner's scope of practice incorporates clinical decision making, administration of medications, invasive and non-invasive clinical interventions and conveyance of patients.'

- Delete sentence: 'Practitioners may provide care ranging from basic life support (BLS) to advanced life support (ALS) depending on their clinical training, medication and equipment available to them.'

(ii) Practitioners other than PHECC Practitioners

- Replace the words 'may be' with 'include:'
- Delete '(doctors)' after 'registered medical practitioners'
- Add the word 'registered' before 'health and social care professionals' and add full stop after 'professionals.'
- Delete 'with appropriate clinical training for pre-hospital emergency care practice, as determined by the regulator in conjunction with PHECC.'

New sentence:
'Practitioners other than PHECC Practitioners, include: registered medical practitioners, registered dentists, registered nurses or midwives or registered health and social care professionals.'

4. **Clinical Care levels;**

- Amend title to 'Clinical Scope'
- Add new paragraph;
  'Responders are certified by PHECC through Approved Training Institutions. Certificates are time limited and it is the responsibility of the responder to ensure that the certificate is maintained in date. Practitioners obtain qualifications and are subsequently registered with an appropriate statutory registration body. They must maintain competency through continuous professional competency (development) and other means. Practitioners are accountable for their clinical decisions and actions through fitness to practice.'

* Stanley Koe joined the meeting.

6. Clinical Developments

6.1 PHECC Field Guide and App

Brian Power provided an update. Ray Carney amended the field guide as agreed at the May MAC meeting and revised Field Guide 2017 was included in the meeting papers for approval. Brian relayed that the field guide will be proof read prior to publication. He reported that following the May meeting feedback was submitted from Martin O'Reilly regarding the Burns CPG. Philip Darcy reviewed the section on poison care and he noted that there is no mention of acid attacks. It was agreed to add acid attacks to the Burns CPG. Philip Darcy, Brian Power and Jason van der Velde will amend the Burns CPG for insertion into the field guide.

It was agreed that the amended Field Guide be presented to Council for information at their September Council meeting. Brian Power requested that the members submit any additional feedback to him.

Resolution: That the Medical Advisory Committee approve the PHECC Field Guide 2017 subject to the changes agreed.

Proposed: Eoghan Connolly **Seconded: Ian Brennan**
Carried without dissent

6.2 Ambulance pre-alert policy

Revised and amended draft National Pre-alert Guidelines v 0.6 was included in the meeting papers for discussion. It was stated that practitioners are not trained to diagnose, their role is to assess the patient and communicate that assessment to the Emergency Department who will decide how to respond. The Chair advised that the guidelines set out the types of situations where the EDs should be pre-alerted. The vast list of specific clinical conditions were referred to and it was questioned if the pre-alert guidelines will be adopted by all Emergency Departments. Brian Power clarified that following approval of the MAC the guidelines will be presented to the Emergency Medicine Programme and recommended to Council

thereafter. Following approval of Council the National Pre-alert Guidelines will become a national standard. He stated that the specific clinical conditions should list symptoms as opposed to specifics.

Following discussion amendments were agreed by the members.

Specific Clinical Conditions:
- add 'include but not limited to'
- Move 'Suspected spinal cord injury with neurology' and add to list of 'Specific Injuries'
- Add 'Suspected' before 'Diabetic Ketoacidosis (DKA)'
- Delete '(Betablockers)' after 'Toxidromes'

Situational:
- Move to after 'Clinical Assessment' and before 'Specific Clinical Conditions'

Resolution: That the Medical Advisory Committee approve the National Pre-alert Guidelines for submission to the Emergency Medicine Programme, subject to the changes agreed.

Proposed: Eoghan Connolly **Seconded: Jason van der Velde**
Carried without dissent

6.3 Pre-hospital tourniquet use

An American Association for the Surgery of Trauma journal article 'Prehospital tourniquet use in penetrating extremity trauma: Decreased blood transfusions and limb complications' was included in the meeting papers for reference. The study demonstrates that prehospital tourniquets can be safely used to control bleeding in compressible penetrating extremity haemorrhage and are associated with decreased blood product utilisation without increased risk of major tourniquet related limb complications. Prehospital tourniquet placement for penetrating extremity haemorrhage effectively provided temporary haemorrhage control until definitive interventions could be performed, which may lead to improved long-term outcomes and increased survival in trauma patients.

Brian Power provided an overview. He stated that a discussion is needed on when and how to use tourniquet. A discussion ensued. It was stated that tourniquet is rarely used in the Irish setting, and when it is, it is used appropriately. Brian stated that the evidence shows that tourniquet use causes very little harm with very little blood loss. Mick Molloy concurred noting that first responders use tourniquet in the United States and it is a good skill to have. It was remarked that there is a lot more catastrophic haemorrhage incidents in farming communities than anywhere else, and the standard procedure is to call for ALS, if ALS arrive and consider it is not a major haemorrhage the tourniquet can be removed.

The members considered should catastrophic haemorrhage control be added to the responder levels scope of practice. It was agreed to add tourniquet to the EMT scope of practice and to add catastrophic haemorrhage control to the responder levels scope of practice. Ian Brennan suggested to add tourniquet use to the triage sieve CPG. It was agreed that Brian Power will liaise with Ian Brennan and the triage sieve CPG will be amended to include tourniquet use.

Resolution: That the Medical Advisory Committee agree to add tourniquet use to the EMT scope of practice. **Proposed: Eoghan Connolly** **Seconded: Jason van der Velde** **Carried without dissent**

Resolution: That the Medical Advisory Committee agree to add catastrophic haemorrhage control to the responders scope of practice. **Proposed: Eoghan Connolly** **Seconded: Jason van der Velde** **Carried without dissent**

* Mick Molloy, David Hennelly and Hillery Collins left the meeting.

7. CPG Development Process

* Dympna Higgins, PHECC Support Officer, joined the meeting for agenda item 7.1.

7.1 Core and non-core CPGs

An updated MAC survey report including all CPGs identified as Core CPGs with specified non-core element(s) was included in the meeting papers. Ricky Ellis circulated a tabled document to the members to provide an overview of their previous survey results and the CPGs that had been identified as core in survey one. He then invited the MAC to assign categories to the remaining CPGs that had been identified in the second survey as having specific elements whereby the service in conjunction with their Medical Director may decide on an implementation strategy. Ricky sought MAC clarification on these items and requested that MAC categorise the outstanding CPGs as (1) Core or (2) Core with non-core elements or (3) Non-core. There was further discussion to clarify what Core with non-core element meant. It was agreed that within the CPG there may be specific intervention(s) identified by MAC that could be considered non-core, while not rendering the entire CPG non-core. The decision to implement non-core elements rests with the licensed CPG provider.

Gerard Bury sought clarification on the purpose of the survey. The Chair clarified that based on legal advice recommending that PHECC cease granting CPG exemptions to licensed CPG providers, Council instructed the MAC to examine the possibility of providing options for CPG providers, such as core and non-core CPGs. Clarification was sought on whether the comments in the survey report relate to entire CPGs or elements within the CPGs, and Ricky Ellis clarified that the majority of the comments relate to elements within the CPGs.

The Chair noted that there are five different routes for administering Midazolam for the AP seizure/convulsion CPG. It was advised that it is good to have options available at AP level. It was agreed that Brian Power will add an information box to the AP seizure/convulsion CPG that 'Anti-convulsant medications should be available via a minimum of two routes for APs'.

It was agreed to delete 'escalating energy defibrillation' from the VF or pulseless VT – Adult CPGs.

The CPGs identified as non-core in their entirety are:

5/6.8.7 Palliative Care – Adult

5/6.9.1 Clinical Care Pathway Decision - Treat & Referral

5/6.9.2 Hypoglycaemia - Treat & Referral

5/6.9.3 Isolated seizure - Treat & Referral

It was agreed that all other CPGs are Core (with some containing non-core elements). Following discussion of the survey results presented to MAC the following are agreed as non-core elements.

EMT	Paramedic	Advanced Paramedic
- Mechanical CPR - Haemostatic dressing	- Mechanical CPR - Manual defibrillation - Wound clips	- Mechanical CPR - Warm fluids - Urinary catheter - Wound clips

Resolution: That the Medical Advisory Committee recommend Core, Core with non-core elements, and Non-core CPGs to Council for approval, subject to the changes agreed.

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

* Jason van der Velde left the meeting.

7.2 EFR CPGs

The EFR CPGs were reformatted to exclude the FAR content. The reformatted draft EFR CPGs were included in the meeting papers for approval.

Resolution: That the Medical Advisory Committee recommend the reformatted EFR CPGs to Council for approval.

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

7.3 Pain CPGs

Revised and amended draft CPGs 4/5/6.2.6 Pain Management – Adult and 4/5/6.7.5 Pain Management – Paediatric were included in the meeting papers for approval. Brian Power highlighted the changes. Gerard Bury registered his discomfort once again with the use of IO Lidocaine for infusion analgesia, as was noted by him at the April MAC meeting.

Resolution: That the Medical Advisory Committee recommend CPG 4/5/6.2.6 Pain Management – Adult and CPG 4/5/6.7.5 Pain Management – Paediatric to Council for approval.

Proposed: Philip Darcy **Seconded: Lisa Cunningham Guthrie**
Carried by a majority – G Bury dissented.

7.4 Stridor CPG

Revised and amended draft CPG 4/5/6.7.13 Stridor – Paediatric was included in the meeting papers for approval. Brian Power highlighted the changes.

Resolution: That the Medical Advisory Committee recommend 4/5/6.7.13 Stridor – Paediatric to Council for approval.
Proposed: Stanley Koe **Seconded: Peter O'Connor**
Carried without dissent

Gerard Bury noted that there is increasing evidence that Methoxyflurane and IV Paracetamol are best care to administer to elderly patients as the non-opiate analgesic option, which can be safely given to elderly patients. He stated that if going to have a choice there should be at least one drug from each class available.

8. Clinical Practice at Events

An update will be provided by the Chairs of the Strategic Development Committees at the September MAC meeting.

* Gerard Bury left the meeting.

9. External communications, consultation, feedback

9.1 Tropicsafe

At the April MAC meeting Brian Power was instructed to contact Murray Ambulance Service for more details on the Tropicsafe project, which aims to develop a training protocol at European level, focused on patient transport professionals with guidelines for a proper and safe transfer of patients with tropical diseases. A detailed response from the Director of Murray Ambulance was included in the meeting papers. Murray Ambulance Service believe that there is a great opportunity for the good work of PHECC to be extended throughout different programs in Europe and they are encouraging the MAC to engage as a stakeholder on this programme with a view to perhaps becoming a partner in future programs. Following discussion it was agreed that Brian Power will write to the Director of Murray Ambulance Service thanking him for this information and advising that the MAC would like to be kept informed on the progress of the Tropicsafe project.

10. AOB

There being no other business the meeting concluded at 15:30 approximately. The next meeting of the Committee will be held at 10:00am in the PHECC office on Thursday 26th September 2019.

The Chair thanked all present for their attendance.

Signed: _____ **Date:** 28.11.19

Chair