Medical Advisory Committee

Meeting Minutes

25th April 2019, PHECC office @ 10:00am

Present
David Menzies (Chair)
David Irwin (Vice Chair)
Gerard Bury
Philip Darcy
Ian Brennan
Shane Mooney
Martin O'Reilly
Hillery Collins
Eoghan Connolly
Niamh Collins
Macartan Hughes
Peter O'Connor

Apologies
Stanley Koe
Cathal O'Donnell
Jason van der Velde
Mick Molloy
David Hennelly

Absent
Lisa Cunningham Guthrie
Mark Dixon
Shane Knox

In attendance
Brian Power, PHECC PDO
Ricky Ellis, PHECC PDO
Margaret Bracken, PHECC Support Officer

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1. Chair's Business

The Chair welcomed the members. Apologies were noted. Condolences were expressed to Professor Patrick Plunkett, Council member, on the death of his mother.

2. Minutes from March 2019 meeting

The minutes of the meeting held on 7th March 2019 were reviewed. Some amendments were highlighted and agreed by the members.

Agenda items; 6.6 Epinephrine Nebs for Paramedic scope of practice and 6.7 Dexamethasone for Croup

i) Change 'no risk' to 'minimal risk'.

Agenda item 6.8 Consideration of C-Circuit introduction

ii) Change 'the onus is on licensed CPG providers to adopt this system' to 'licensed CPG providers may decide to adopt this system'.

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 7th March 2019 subject to agreed amendments.

Proposed: Hillery Collins **Seconded: Niamh Collins**
Carried without dissent

2.1 Matters Arising

- Agenda item 3.2 Naloxone maximum:

Martin O'Reilly queried if the CPGs were amended to reflect the MAC resolution that 'PHECC practitioners may consider administering further doses of Naloxone if Naloxone has administered prior to arrival'. Brian Power advised that, as agreed by the MAC, the medication formulary, field guide and field guide app, would be updated to reflect this decision, and the CPG would remain the same.

- The discussion on the introduction of a C-Circuit for ventilation of paediatric patients evolved into a conversation about Ondansetron PO for paediatrics and no conclusion was reached on its introduction to the advanced paramedic and paramedic scope of practice. It was indicated that some EMTs who are involved in critical care transport may require this intervention in their scope of practice. The members agreed a resolution to reflect the discussion.

Resolution: That the Medical Advisory Committee endorse the option for licensed CPG providers to consider the use of a flow inflating bag valve device and that it be added to the skills matrix as a special authorisation for practitioner level.

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

3. Clinical Queries

There were no clinical queries for discussion.

4. Correspondence

4.1 NIV for asthma and Exacerbations of COPD

Correspondence from a paramedic intern, submitted through David Irwin for consideration of the MAC, was in the meeting papers. The proposal is to add Non-Invasive Ventilation (NIV) to the scope of practice to treat patients with acute asthma and exacerbations of COPD. CPGs from other ambulance services and their different utilisations of NIV for COPD and asthma was included with the correspondence. David Irwin provided an overview. The members noted that a lot of effort was put into this submission and commended it as an excellent piece of work. This query was discussed in conjunction with agenda item 9.1 COPD report.

5. MAC Strategy 2017-2020

5.1 Strategic Development Committees

An update was provided by the Chairs of the Strategic Development Committees.

Treat and Refer: Brian Power reported that his research with GPs is ongoing and he will have an update for the September MAC meeting.

Critical Care Paramedic: Ian Brennan reported that he presented to the NAS Critical Care and Retrieval Services Committee a few weeks ago and his presentation was very well received. A plan for moving forward is being decided and an update will be provided at the September MAC meeting.

Community Paramedic: Hillery Collins reported that Brian Power and Cathal O'Donnell are identifying medications for inclusion on the seventh schedule update submission. Hillery is awaiting data from the Clinical Pathway Manager for Co-operation and Working Together (CAWT) Health and Social Care Partnership, who have established Community Paramedic services in Northern Ireland and Ireland. A meeting of the subcommittee is being arranged for mid-May and an update will be provided at the September MAC meeting.

The Chair tabled the draft response from MAC/PHECC to the survey 'Optimal HEMS clinical crewing models stakeholder feedback'. The survey provided a list of competencies and requested practitioners to select 'the optimal clinical competencies within the provision of HEMS for Ireland' with a section provided for comments. The Chair informed the members that the survey was sent to the PHECC Director who has requested that the MAC reply on PHECC's behalf. The survey was circulated to the critical care paramedic subgroup. Niamh Collins stated that she is fully supportive of this, however, advised caution when setting a minimum standard stating that the clinical competencies should not prevent standard critical care, and that a minimum standard is not necessarily the desired standard. Hillery Collins noted that the comments on the survey are from APs only and exclude paramedics and EMTs, who should be included in the discussion. Ricky Ellis advised of the need to be mindful of the impact this may have on organisations such as the Irish Coastguard and Helicopter Search and Rescue. The Chair stated that the survey sets out what the skill set should be and not who should do it. Brian was requested to submit the survey and add a narrative that; 'The minimal standard is not necessarily the desired standard. The interventions that are commonly encountered must be the absolute minimum standard, however, there are also anticipated interventions that are less frequently encountered but critical to reduce mortality and morbidity and must be considered.'

5.2 Pre-hospital emergency care practice for Ireland

A revised draft document 'Pre-hospital emergency care practice for Ireland' was included in the meeting papers for discussion. The document aims to define pre-hospital emergency care and standardise pre-hospital clinical level of care terminology in Ireland.

The members reviewed the draft document and suggestions were made. Gerry Bury advised that the legal framework needs to be considered and a legal and professional context needs to be added in order for PHECC to enforce it. He stated that the draft document applies more to volunteers, PHECC practitioners and responders, and not to doctors and nurses. He advised that doctors and nurses need to be engaged with proactively. He suggested the document be redrafted as a discussion document to identify critical issues and options. Niamh Collins referred to the definition under 'practitioner' with reference to 'registered medical practitioners, or registered nurses or midwives with appropriate clinical training for pre-hospital practice'. She suggested that the definition of practitioner in this context be changed and queried who the accrediting training body is for pre-hospital practice for registered medical practitioners, nurses and midwives.

The inclusion of a definition for 'Good Samaritan' was discussed. It was suggested to add an acknowledgment to the document that Good Samaritan does not fall into this process. David Irwin suggested that definitions for Good Samaritan and volunteers from the Civil Law (Miscellaneous Provisions) Act 2011 could be considered for inclusion.

Following discussion, amendments were agreed to the draft document 'Pre-hospital emergency care practice for Ireland'.

1. Introduction
   - Add 'clinical decision making' to read: 'They bring welcome, but vastly varying levels of competence, clinical decision making, equipment and medications to the scene.'
   - Add legal framework.

4. Pre-hospital emergency care definition
   - 4 (i) Divide practitioners into two groups, 'PHECC practitioners' and 'Other registered practitioners'.
   - 4 (ii) Responder; Add the word 'varying' to read 'Local authority firefighters, Gardai and Defence Forces personnel are all trained to varying PHECC responder levels'.

6. Clinical Level of Care in Practice
   - 6.6 Retrieval Medicine Teams; paragraph to be rephrased in a more positive light.

Brian Power will circulate a word document of 'Pre-hospital emergency care practice for Ireland' to MAC members, for members to make track changes, and responses are to be submitted to Brian within two weeks. The feedback will be discussed at the May MAC meeting.

The Chair commended Brian and Jason on the considerable work they have done on this project.

6. Clinical Developments

6.1 Pre-alert guidelines

The draft National Pre-Alert Guidelines v 0.5 were included in the meeting papers. Brian Power emphasised that this guideline must have buy in from both PHECC and the Emergency Medicine Programme (EMP) to be effective. He stated that the draft pre-alert guidelines have already been approved by the MAC, but that engagement with the EMP has been reduced since Dr King's death. The document has been resubmitted to MAC in light of the spinal injury management policy and prior to re-engaging with the EMP. He advised that 'Mechanism of Injury' section needs to be revised.

Niamh Collins informed the members that nurses in the ED in Connolly Hospital have reported to some concerns regarding spinal fractures recently and she will report back to the Committee when she has received all the feedback from the nurses. Gerry Bury queried who decides when a patient needs to be pre-alerted to the ED. It was clarified that there was a lot of deliberation regarding this when the guidelines were previously discussed by the Committee. The consensus was that the practitioner assesses the patients, pre-alerts the hospital and provides the appropriate information. The hospital in turn decides what clinical resources are required. Hillery Collins advised that there can be issues with pre-alerting as every hospital is different, and the definition of pre-alert is based on what practitioners think. David Irwin concurred with Hillery and he stated that a minimum standard document is good, but it shouldn't preclude what other information practitioners need to inform the EDs. The Chair advised that there will always be variances in EDs, practitioner discretion is crucial and there is an element of good faith involved. He stated that EDs always need to know when an immediate clinical intervention is required when the patient arrives at the ED. He stated that the pre-alert guidelines can be added to which could help predict trauma destination. Eoghan Connolly advised that there are occasions where practitioners are asked why they didn't pre-alert and that guidance for practitioners is good practice.

Gerry Bury stated that we need a focused agreed process of what guidelines are required to identify whether a practitioner needs to pre-alert the ED. He noted that he has difficulties with gaps in the document as presented and pointed out that heart attack and unstable angina among others are not included.

Following discussion, it was agreed to add the following to the list of Specific Clinical Conditions.

- Diabetic ketoacidosis (DKA)
- Life-threatening asthma
- Burns > 10%
- Stridor
- Toxidromes (Betablockers)
- Acute confused states
- Severe uncontrolled pain

It was suggested that 'non-STEMI suspected' be added to 'STEMI suspected'

Hillery Collins queried about focusing so much on numbers and figures for clinical assessments as it is not absolutist. The Chair advised caution and noted that the ePCR could address this issue. He advised that the Committee need to revisit this.

Brian Power will make the agreed amendments and revised draft national pre-alert guidelines will be submitted for consideration at the May MAC meeting prior to submission to the Emergency Medicine Programme.

* Macartan Hughes joined the meeting.

6.2 EFR add-on for Mountain Rescue

A draft paper proposing a PHECC solution to the Mountain Rescue Ireland request that consideration be given by PHECC to enhance the scope of practice for EFRs when providing care on behalf of a mountain rescue team was discussed.

David Irwin chaired this agenda item as the Chair declared a conflict of interest. The members discussed a potential new practitioner clinical level on the register between EFR and EMT, what skill set/medications should be included and what this encompasses, how to progress, what to call this new grade/subdivision and training/course duration. It was advised that new legislation would be required to add a new division to the PHECC register. However, the potential new clinical level could be accommodated within the EMT division as a level within this division. Ian Brennan strongly cautioned against diluting the EMT clinical level. It was suggested that other non PHECC licensed CPG providers involved in rescue i.e. RNLI, Cave Rescue etc., may also be interested in pursuing this potential clinical level.

Gerry Bury advised that clinical interventions and medications proposed for inclusion in MRI responder scope of practice, as set out in the draft response document, should be prerequisites for people working in the remote and austere environment and should be determined by PHECC. Ian Brennan stated that Dublin Wicklow Mountain Rescue Team are a PHECC licensed CPG provider and he strongly encourages all other

mountain rescue teams to do likewise. Eoghan Connolly noted that some mountain rescue teams have a very low number of calls per year as per the 2017 Mountain Rescue Ireland Annual Report which may prohibit skills retention.

Medical oversight for rescue teams was discussed. A PHECC framework with a core skill set, and medications authorised for administration with medical oversight, was suggested as an alternative.

Hillery Collins advised that access to pain relief is the biggest issue facing rescue services in remote and austere environments and that this problem does not just apply to mountain rescue teams alone. He noted that Methoxyflurane has only recently been introduced to some offshore islands. Martin O'Reilly suggested that a request be made to the DoH to add Methoxyflurane to the medications for listed organisations. Brian Power advised that the Tenth Schedule was updated recently by the DoH and Methoxyflurane was not included, despite being requested to do so. During discussion it was confirmed that the EFR level may administer Entonox for pain relief, provided that they are operating on behalf of a 'Listed Organisation' (SI 449 of 2015). It was also confirmed that EFR BTEC may be included as part of EFR recertification for rescue teams. Niamh Collins suggested developing a standard for remote and austere environments in general and not just for MRI and cautioned against having multiple skill sets. The administration of Paracetamol and/or Ibuprofen for pain relief was discussed. Gerry Bury stated that anyone may give Paracetamol and Ibuprofen and he suggested that PHECC issue an advisory to all licensed CPG providers. It was suggested that an advisory note be circulated to include that CPGs are to be acted on with medical oversight from a senior clinician.

Following discussion, the MAC do not recommend the introduction of a new practitioner level below EMT for the skills submitted by Mountain Rescue Ireland.

Brian Power to respond to MRI advising them:

1) that the MAC recommend that EMT is the minimum practitioner level for remote and austere environments;
2) that EMT BTEC should be considered to introduce some additional skills;
3) that Entonox can be administered for pain relief at EFR level provided that the EFR is operating on behalf of a Listed Organisation (SI 449 of 2015);
4) that PHECC will request the DoH to include Methoxyflurane on the Tenth Schedule.

*David Menzies resumed chairing the meeting.

6.3 CPP – IO access & analgesia

Brian Power highlighted the changes to CPG 4/5/6.2.6 Pain Management - Adult and CPG 4/5/6.7.5 Pain Management – Paediatric and the Clinical Practice Procedure, as agreed at the March MAC meeting.

It is noted that Gerry Bury has registered his discomfort with the use of IO Lidocaine for infusion analgesia as in his opinion there is no evidence for this practice. He requested that his dissention from this MAC decision be recorded. David Irwin provided the context advising that IO Lidocaine for infusion analgesia was introduced to the CPGs for patients where IV access is not available.

Shane Mooney advised that all NAS practitioners in the East are familiarised to use IO Lidocaine and there have been no issues with this process to date.

The members reviewed the Clinical Practice Procedure for IO. A small typo was highlighted which will be amended by Brian Power.

Resolution: That the Medical Advisory Committee recommend the Clinical Practice Procedure for IO to Council for approval subject to the agreed amendment.

Proposed: David Irwin **Seconded: Shane Mooney**
Carried with one dissent from Gerry Bury

Some further amendments were suggested and agreed to CPG 4/5/6.2.6 Pain Management - Adult and CPG 4/5/6.7.5 Pain Management – Paediatric.

CPG 4/5/6.2.6 Pain Management – Adult

- Box: IO Access & Analgesia
  - Lidocaine 1%, 40 mg IO; add 'over 2 minutes'
  - 2nd dose, 20 mg Lidocaine 1%, over 1 minute; add 'wait 1 minute'
  - Delete box; Infuse 20 mg Lidocaine 1%, over 2 minutes, following IO needle insertion
  - Supplementary dose of Lidocaine; add '20 mg' to read 'Supplementary dose of 20 mg Lidocaine 1% x 1 prn (no sooner than 45 mins)'

- Add hyphen between Poly and opiate administration to read 'Poly-opiate'

CPG 4/5/6.7.5 Pain Management – Paediatric

- IO Access & Analgesia; amend as per CPG 4/5/6.2.6 Pain Management – Adult
- Add box: Do not administer Amiodarone and Lidocaine
- Add hyphen between Poly and opiate administration to read 'Poly-opiate'

Gerry Bury queried why the dose of Ketamine was increased and whether there was any data to support this. The Chair explained that the original dose was conservative and has been changed to a higher dose which is used internationally. Niamh Collins noted that it would be beneficial to look at Ketamine use. Brian Power advised that there are PHECC KPIs around pain management which could be used to capture pain audits. Ricky Ellis noted that reporting adverse clinical events is a component of the Governance Validation Framework. Prof Bury advised that PHECC should have a policy in place to protect itself, as the CPGs may be exposing PHECC to risk, especially as there is no feedback loop to advise of actual or potential adverse events directly attributed to compliance with a CPG. The Chair will take this matter to Council.

Brian Power to amend the CPGs as agreed. Revised and amended drafts to be included at the May MAC meeting for consideration.

6.4 Subgroup report – Sedation
6.5 Concussion
6.6 Emergency Obstetrics CPGs

There was no update on these agenda items.

* Gerry Bury and Philip Darcy left the meeting.

6.7 PHECC Field Guide and App

Brian Power provided an overview on the progress of the development of the new field guide and field guide App. Ray Carney was seconded as a Programme Development Officer while Brian was acting Director. Part of his duties was to manage the development of the App and field guide in parallel to ensure consistency. A comprehensive survey of registrants was carried out by PHECC on the previous field guide and content suggestions were received and developed as a result. A focus group was formed, and the latest draft was circulated only to the focus group. PHECC omitted to include 'draft' on the circulated PDF and the draft document was circulated by members of the focus group to a wider audience despite specific instructions not to do so. Based on feedback received from practitioners the draft document has been further updated and this process will continue until it is ready for publication. There was a strong request from practitioners for the addition of age per page, an example of which was included in the meeting papers.

Brian stated that it has been a complex process to bring the whole project together. He advised that PHECC will have control over the content of the App once it is uploaded to the host site, and PHECC can release/ not release content pages as required, when the App is being released. Shane Mooney asked if the field guide will be available in hardcopy. This was supported by Niamh Collins. Brian advised that this is a matter for Council. He advised that the field guide contains the medication calculations and decision making supports only whereas the App will incorporate the CPGs. Brian advised that all licensed CPG providers were asked to specify how many 2017 medications field guides they required. These were distributed free of charge, and it has transpired that some organisations have boxes of field guides and have not distributed them.

Macartan Hughes commented that the age per page is difficult to look at on the screen as there is so much information on the page. Brian advised that the screen can be expanded. David Irwin noted that the age per page can be printed as A4 sheets and laminated. Martin O'Reilly requested a timeframe for the App and Brian advised it is anticipated to be ready in the next couple of months. Hillery Collins noted that the field guide is not a substitute for the published CPGs, it is a quick reference to help practitioners in the field. Niamh Collins suggested the colour of the headings in the age per page be changed as they are the same colour which identifies as paramedic, and the concentrations be changed from mg to mcg where appropriate as per the agreed dose convention.

The Chair noted his concern that some of the content of the new field guide is not included on any CPGs and stated that he would have difficulty as the Chair of MAC with the new field guide being released without being reviewed and approved by the MAC. David Irwin concurred with the Chair advising that he identified some errors. Martin O'Reilly stated that the field guide should be reviewed by the MAC based on the current CPGs.

The Committee agreed that a review process such as a Delphi process would be the correct way forward. Brian Power to send on the new field guide to all MAC members, and feedback will be discussed at the May MAC meeting.

* Ricky Ellis left the meeting and was absent for agenda items 7.2, 7.3 and 7.4.

7. CPG Development Process

7.1 Core and non-core CPGs

Ricky Ellis provided an update informing the members that out of nine members resurveyed only four have responded. He will provide a further update at the May MAC meeting.

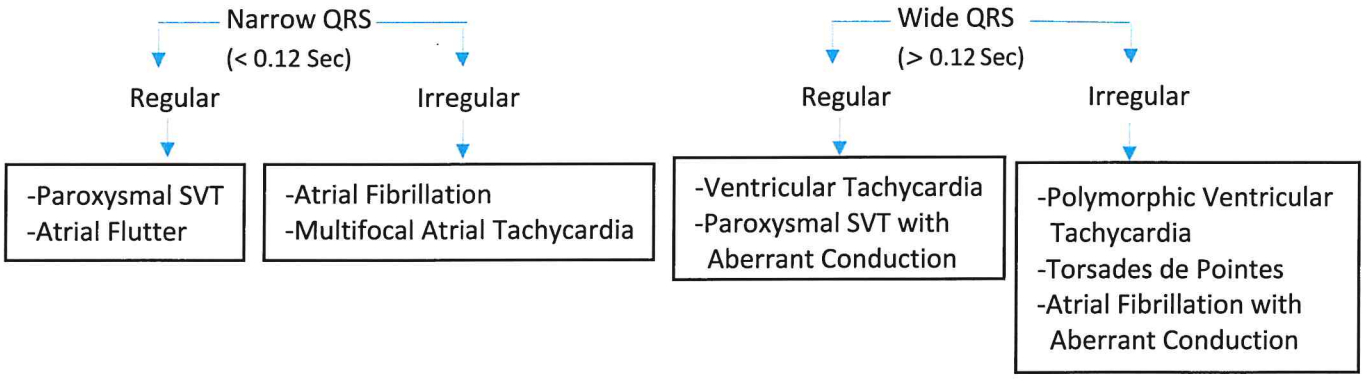
Tachycardia CPG

Brian Power was tasked to draft PHECC style CPGs based on the revised version of Tachycardia CPGs presented by David Irwin. Draft Tachycardia CPGs were included in the meeting papers for review. The Chair informed the group that Gerry Bury noted his approval of the draft Tachycardia CPGs before he left the meeting.

Following discussion some further amendments were suggested and agreed.

CPG 5/6.4.12 Tachyarrhythmia Overview

New outline;



CPG 5/6.4.x Tachyarrhythmia Narrow QRS / Regular Rate

- Remove 'vagal' to read 'Valsalva Manoeuvre'
- Move 'Sync' to before 'Cardioversion' wherever it appears to read 'Sync Cardioversion'
- Change dose of NACL 0.9% IV from 250 mL to 500 mL
- 'If initial Adenosine unsuccessful repeat at 12 mg x 2 prn Max' was discussed and will be revisited.

CPG 5/6.4.xxx Tachyarrhythmia Wide QRS / Regular Rate

- Amiodarone 150 mg IV infusion (in 100 ML D_5W); add 'over 10 minutes'
- Move 'Sync' to before 'Cardioversion' wherever it appears to read 'Sync Cardioversion'
- Change dose of NACL 0.9% IV from 250 mL to 500 mL

CPG 5/6.4.xxxx Tachyarrhythmia Irregular Rate

- Move 'Sync' to before 'Cardioversion' wherever it appears to read 'Sync Cardioversion'
- Change dose of NACL 0.9% IV from 250 mL to 500 mL
- Delete box; Do NOT administer Adenosine IV to Afib with WPW

Brian Power to amend the draft Tachycardia CPGs as agreed for review at the May MAC meeting.

7.2 Adrenal Crisis CPGs

At the March meeting the MAC discussed an email which was received via NAS from a member of the public regarding the management of patients experiencing an adrenal crisis. Following discussion amendments to the Adrenal Crisis CPGs were agreed. Brian Power informed the members that a draft letter of response was sent to the member of the public addressing the concerns raised and he received a reply thanking him for the advice.

Revised and amended draft CPGs were included in the meeting papers and Brian Power highlighted the changes. Some further amendments were suggested and agreed by the members.

CPG 5/6.4.13 Adrenal Insufficiency – Adult

- Delete diamond; SBP < 90 mmHg
- Consider Hydrocortisone 100 mg IM; delete 'if IV not available'

CPG 5/6.7.30 Adrenal Insufficiency – Paediatric

- Delete diamond; Poor perfusion
- Consider Hydrocortisone IM; delete 'if IV not available'
- The clinical presentation of an Addisonian Crisis can include: bullet pt. 3; replace 'Hypotension when sitting or even lying' with 'Poor perfusion'

Stanley Koe expressed concern at the March MAC meeting regarding the dose of 50 mg Hydrocortisone IV/IM for 6-month olds. He stated that he would carry out a review on this dose and the CPG would be amended as a matter of urgency based on this review. Brian Power advised that he has received no update from Stanley.

Brian Power to amend the draft Adrenal Crisis CPGs as agreed for review at the May MAC meeting.

7.3 Stridor

At the March Meeting the MAC agreed to include Epinephrine Nebulisation in the paramedic scope of practice. Revised and amended draft CPG 4/5/6.7.13 Stridor – Paediatric was included in the meeting papers. Some further amendments were suggested and agreed.

Add box:
Severe croup may include:

- Hypoxia
- Respiratory distress
- Stridor at rest
- Irritability and/or lethargy
- Marked increase in respiratory rate

Brian Power to amend draft CPG 4/5/6.7.13 Stridor – Paediatric as agreed for review at the May MAC meeting.

* Hillery Collins left the meeting.

8. Clinical Practice at Events

8.1 Clinical Care at Events Subcommittee

There was no update on this agenda item.

* Ricky Ellis returned to the meeting and provided an update on Agenda item 7.1 Core and non-core CPGs.

9. External communications, consultation, feedback

9.1 COPD report

An extract from the 2019 report 'Global strategy for the diagnosis, management and prevention of COPD' from The Global Initiative for Chronic Obstructive Lung Disease (GOLD) was contained in the meeting papers. A hyper-link to the full report was included. Brian Power provided an overview. Following discussion, it was agreed to consider a review of the evidence for non-invasive ventilation for Asthma and COPD. Brian Power will amend accordingly, and revised updated CPGs will be reviewed at the May MAC meeting.

9.2 Tropicsafe transport

A document from Tropicsafe 'Medical transport of patients with tropical diseases in safe conditions' was included in the meeting papers for information. The Tropicsafe project aim is 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. Brian Power informed the members that Murray Ambulance Service are involved with this group in partnership with other European pre-hospital organisations. The Chair tasked Brian to contact Murray Ambulance Service for more details.

9.3 Mechanical V manual chest compressions

A BMC journal article 'A meta-analysis of the resuscitative effects of mechanical and manual chest compression in out-of-hospital cardiac arrest patients' was included in the meeting papers for information. Shane Mooney noted that this is a training issue. The Chair suggested an addendum to the CPGs and Niamh Collins suggested waiting for an ILCOR statement before amending CPGs.

9.4 Head up/ chest up compressions

A Critical Care Medicine journal article 'Confirming the clinical Safety and feasibility of a bundled methodology to improve cardiopulmonary resuscitation involving a head-up/torso-up chest compression technique' was included in the meeting papers for noting.

10. AOB

10.1 David Irwin noted that the definition of STEMI in the field guide is different to the definition of STEMI in the CPGs and this needs to be corrected. Ambulance crews are transporting patients to EDs based on the PHECC CPGs. Brian Power advised that the definition of STEMI is agreed with the ACS Programme and will confirm their current definition.

10.2 Martin O'Reilly noted that feedback he has received from practitioners on the ground indicates that there is a conflict between some EDs and PHECC protocols for fluid resuscitation with haemorrhage management. EDs are focused on permissive hypotension. It was agreed that MAC would review this issue.

10.3 Eoghan Connolly requested an update on the stroke clinical programme. Brian Power advised that he was in contact with the programme and they are very impressed with PHECC involvement to date.

10.4 It was agreed that the May MAC meeting will focus on the following agenda items.
Field guide, pre-hospital emergency care practice for Ireland, core and non-core CPGs, revised and amended Tachycardia CPGs.

There being no other business the meeting concluded at 15:30 approximately.

The next meeting of the Committee will be at 10:00am in the PHECC office on Thursday 30th May 2019.

Signed: _____ **Date:** 27.7.19

Chair