Medical Advisory Committee

Meeting Minutes
25th June 2020
Online and PHECC offices @ 10:00am

Present
David Menzies (Chair)

Video Conference
David Hennelly
Cathal O'Donnell
Ian Brennan
Stanley Koe
Shane Mooney
Hillery Collins
Martin O'Reilly
Eoghan Connolly
Niamh Collins
Gerard Bury
Macartan Hughes
Mick Molloy

Apologies
David Irwin (Vice Chair)
Shane Knox
Philip Darcy
Jason van der Velde

Non-Attendance
Lisa Cunningham Guthrie
Mark Dixon
Peter O'Connor

In Attendance
Brian Power, PHECC Programme Manager
Ricky Ellis, PHECC Programme Manager (VC)
Margaret Bracken, PHECC Committee Officer
Aisling Ryan, PHECC Support Officer

1. Chair's Business

The Chair welcomed everyone to the meeting noting apologies received. He informed the group that Brian Power is due to retire on 30th June 2020 and this is his final MAC meeting. There is no replacement Clinical Programme Manager yet. The Chair advised that there is a large agenda for today's meeting. The focus of the meeting will be to review and agree the draft CPGs as presented in the meeting papers. Following Council approval, the CPGs will be included in the 2020 suite of CPGs due to be published shortly. CPGs not agreed at this meeting will be reviewed at a future meeting. The field guide will be updated accordingly. The next MAC meeting scheduled for 30th July will focus on Community Paramedic, Critical Care Paramedic, Palliative Care CPG, and Treat and Refer CPGs with associated education and training package.

2. Minutes from May 2020 meeting

The minutes of the meeting held on 28th May 2020 were reviewed and approved.

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 28th May 2020.
Proposed: Mick Molloy **Seconded:** David Hennelly
Carried without dissent

2.1 Matters arising

The importance of having a more robust link with the Medicines, Controlled Drugs and Pharmacy Legislation Unit, Department of Health (DoH) was noted. This would ensure that the recent issue regarding the removal of Methoxyflurane from the Seventh Schedule, without warning or engagement with PHECC, does not arise in the future. Brian Power stated that these cases are rare, there is a need to be constantly proactive, and

PHECC was very proactive in this situation. Following representations from PHECC and NAS to the DoH, the decision regarding Methoxyflurane was reversed and the medication has been reinstated to the Seventh Schedule. The Chair advised that PHECC will work to strengthen the link with the DoH Medications Unit.

The importance of PHECC engagement with the National Clinical Care programmes and linking with these programmes at an early stage, with respect to implications for medications, was noted. It was agreed that the Chair will write to all National Clinical Care programmes to verify that PHECC are linked in with them and to raise a stronger awareness of PHECC.

Gerry Bury spoke to his dissent from the MAC resolution that *'Methoxyflurane is recognised to be a safe and effective analgesic medication for adults and children and the MAC will work to have it fully restored to the Seventh Schedule as a matter of priority.'* He informed the meeting that he communicated the reasons for his dissent in a letter to the Chair of MAC and PHECC Director. The Chair will circulate the letter to the members. Prof Bury stated that the issue was pursued very well at the May MAC meeting in the context of the appalling misuse of Methoxyflurane by an individual at the centre of a court case which took place that week. He raised concerns regarding the absence of monitoring and safeguards of Methoxyflurane, stating that the absence of adequate monitoring and fitness to practice systems raises the fundamental question of whether PHECC can protect the public in this regard. He advised that PHECC can better protect the public by ensuring that medications are as safe as possible and cannot be misused. He suggested that PHECC request that the DoH add Methoxyflurane to the schedule of controlled drugs. Prof Bury emphasised the importance of further discussion of these issues by Council and MAC. The members agreed that further discussion is warranted. The Chair advised that Council have discussed these matters and he will make recommendation to Council for further discussion. He advised that stronger primary legislation needs to be in place with respect to fitness to practice. Prof Bury questioned what indemnities exist in terms of a mandate offered for off-label drugs within the context of PHECC CPGs. He stated that most of the responsibility lies with the MAC in this regard. The Chair imparted that he will be attending a meeting with the PHECC Director and DoH, and all the issues raised will form part of the discussion and further clarification will be sought. The Chair also noted that the DoH restored Methoxyflurane to the Seventh Schedule in the knowledge that this included off-label use.

Hillery Collins stated that, as part of the PHECC Governance Validation Framework and Quality Assurance processes, PHECC Licensed CPG Providers must ensure that they have acceptable drugs management systems in place. He advised that Council and PHECC cannot take responsibility for the actions of individuals. With reference to off-label medications he stated that off-label medications can be used by law provided that PHECC Committees have robust discussions and a record is kept of these discussions.

3. CPG Development Process

3.1 Sedation/Analgesia CPGs

As agreed at the May meeting the Chair, David Hennelly, Jason van der Velde and Brian Power reviewed and amended the Procedural Sedation/Analgesia - Adult and Paediatric CPGs. Revised draft CPGs were included in the meeting papers for further review. Brian Power highlighted the changes.

A discussion was had regarding administration routes and doses for Ketamine and consideration was given to adding Ketamine IM as a non-core element to both adult and paediatric CPGs.

Clarification was sought on the rationale for Ketamine IV on both adult and paediatric CPGs. It was clarified that in the past Ketamine IM was used which potentially meant carrying very high doses and differing concentrations of the medication. It was cautioned that the dose of Ketamine 0.5-1 mg/Kg IV is a high dose for practitioners who may not have a lot of experience administering the medication. David Hennelly advised that a robust education and training programme will need to be provided to practitioners. Brian Power clarified that the routes of Ketamine available on the Seventh Schedule are IN, IM and IV. Allowing repeat doses of a high dose of Ketamine was raised as a concern as this is moving more into an anaesthetic dose. It was questioned whether 'repeat PRN to maintain sedation' as per medications pain ladder is appropriate. It was agreed to amend this to 'repeat PRN based on clinical need' on both adult and paediatric CPGs. The Royal College of Emergency Medicine (RCEM) Guidelines were referenced. It was agreed to add a repeat regime for Morphine, Midazolam, Fentanyl and Ketamine, as per RCEM Guidelines to both adult and paediatric CPGs.

It was noted that Ketamine is administered on rare occasions. It was stated that the smaller Licensed CPG Providers may not be confident using Ketamine. It was advised that privileging is at the discretion of the service providers. It was agreed to add 'If no IV access consider Ketamine 5 mg/Kg IM' to both adult and paediatric CPGs as a non-core element. It was agreed that the doses of Ketamine are safe, and a robust education and training programme will be developed.

Following discussion changes were agreed to both the adult and paediatric CPGs and Brian Power amended the CPGs accordingly.

Procedural Sedation/Analgesia – Adult CPG

- Delete 'standards' to read; 'Ensure minimal monitoring equipment where possible'
- Delete box – 'Agitated patient: RASS ≥ 1'
- Delete 'standard' and add '/' to read; 'Minimum monitoring/equipment'
- Delete box – 'Minimum monitors attached'
- Add new box as non-core element – 'If no IV access consider Ketamine, 5mg/Kg, IM'
- Amend spelling error - 'Cyclizine'
- Change 'Repeat PRN to maintain sedation' to read; 'Repeat PRN based on clinical need'
- Add new box (as per RCEM guidelines)

Repeat regime
Morphine: 2 mg IV after 2 minutes
Midazolam: 2.5 mg IV after 2 - 5 minutes
Fentanyl: 25 - 50 mcg IV every 2 minutes
Ketamine: 0.5 mg/Kg IV every 5 - 10 minutes
Ketamine: 2 - 2.5 mg/Kg IM every 5 - 10 minutes

Procedural Sedation/Analgesia – Paediatric CPG

- Delete 'standards' to read; 'Ensure minimal monitoring equipment where possible'
- Delete box – 'Agitated patient: RASS ≥ 1'
- Delete 'standard' and add '/' to read; 'Minimum monitoring/equipment'
- Add box; 'If no IV access consider Ketamine, 4-5mg/Kg, IM'
- Change 'Repeat PRN to maintain sedation' to read; 'Repeat PRN based on clinical need'
- Add new box (as per RCEM guidelines)

Repeat regime Morphine: 50 mcg/Kg IV after 2 minutes Midazolam (6 mths – 5 years): Up to 200 mcg/Kg IV after 2 – 5 minutes to Max of 6 mg Midazolam (6 – 12 years): 100 mcg/Kg IV to Max of 10 mg Fentanyl: 1.5 mcg/Kg IV after 10 minutes Ketamine: 0.5 - 1 mg/Kg IV after 5 – 10 minutes Ketamine: 2 – 2.5 mg/Kg IM every 5 – 10 minutes

Subsequent to discussion, the following resolution was passed.

Resolution: That the Medical Advisory Committee recommend Procedural Sedation/Analgesia – Adult and Procedural Sedation/Analgesia – Paediatric CPGs to Council for approval. **Proposed:** David Hennelly **Seconded:** Mick Molloy Carried without dissent

3.2 Pain Management CPGs

At the May meeting the MAC recommended to Council, that due to changes to Methoxyflurane on the Seventh Schedule, the adult and paediatric Pain Management CPGs be approved as a matter of urgency. At the June Council meeting Brian Power updated Council that the situation has been resolved and Methoxyflurane has been reinstated to the Seventh Schedule. In light of the patient safety issues caused by these recent events, Council suggested that the Executive correspond with the Department of Health regarding same and request that PHECC are consulted when changes are contemplated that might affect the practice of paramedicine.

3.3 Treat and Referral CPGs

At the May meeting the MAC agreed to proceed with development of treat and referral CPGs for Toothache, Hypoglycaemia, Seizure, Pepper (Oleoresin) spray, Minor wounds (not requiring suturing), Non injured following trauma (RTC), Mild bronchospasm (controlled by Salbutamol), Epistaxis (controlled by pressure) and Mild allergy. Draft CPGs were included in the meeting papers and Brian Power provided an overview. The CPGs were drafted based on the recommendations from Brian's PhD on Treat and Referral which was presented at the May MAC meeting and agreed as a framework for the development of Treat and Referral CPGs going forward.

The format and language used throughout the CPGs was discussed. It was stated that the nature of CPGs is directive and concern was noted about the general interpretations of language used in the CPGs. The development of a PHECC framework document was suggested. It was questioned why the REMS score was used. Brian relayed that the field guide app is being updated to include a 2020 branch with parameters linking to a low, medium, and high REMS score. Caution about using scoring systems as snapshots was noted and a high-level education piece for practitioners was suggested. In response to a query it was advised that CPGs do not specify a communication method for referral to follow up pathways. It was stated that it is not the responsibility of PHECC, MAC or the RIs/ATIs to put a communication method in place and the onus for this is on the service providers. It was stated that the clinical care pathway options in the CPGs are not tight enough and clear governance is required. It was suggested and agreed to change 'Treat and Referral' to 'Treat and Refer'.

It was stated that the Treat and Refer CPGs will offer a lot of support to the service providers. It was agreed that although the process is appropriate, the format of the CPGs needs modifying, but this should not restrict the progress of the CPGs. It was agreed that the Treat and Refer CPGs and associated education piece will be further reviewed and discussed at the July MAC meeting.

3.4 Sepsis CPGs

Draft Sepsis and Septic Shock – Adult and Septic Shock- Paediatric CPGs were reviewed at the May MAC meeting and some changes agreed. The consensus was that the CPGs need to be more robust and further review was required. Amended draft CPGs were included in the meeting papers for further review. Brian Power provided an overview of the changes. It was noted that some of the terminology is new and the layout was questioned. Brian Power advised that the CPGs and supporting information were drafted based on guidance received from the Sepsis Clinical Care Programme. It was advised that a robust education piece will be developed.

Following discussion further changes were agreed to both the adult and paediatric CPGs and supporting information. Brian Power made the amendments accordingly.

CPG 4/5/6.4.24 Sepsis & Septic Shock – Adult

- Font size to be consistent
- 'Patient generally unwell with suspected infection' - add '< 36^{o}C or > 38.3^{o}C' after 'infection'
- Amend 'three' to '3' and put into inverted commas - "Give 3"
- Change 'Signs of poor perfusion' to 'Signs of hypoperfusion'
- Remove from CPG and add to Sepsis supporting information - 'if history of penicillin allergy assess the severity of the reaction and if not life-threatening i.e. rash, proceed with Ceftriaxone'

CPG 5/6.7.34 Septic Shock – Paediatric

- Font size to be consistent
- Replace '?' following 'infection' with 'considered' to read; 'Abnormal physiology? Source of infection considered'
- Replace 'organ dysfunction' with 'inadequate perfusion' to read; 'Evidence of inadequate perfusion'
- Remove Sepsis Amber Flag and Risk Factors from supporting information and add to CPG

Paediatric Sepsis supporting information

- Add to top of document – 'Indications of abnormal physiology'
- Delete Sepsis Red Flag and move Sepsis Amber Flag and Risk Factors to CPG
- Add box; 'If history of penicillin allergy assess the severity of the reaction and if not life-threatening, i.e. rash, proceed with Ceftriaxone'

Subsequent to discussion, the following resolutions were passed.

Resolution: That the Medical Advisory Committee recommend CPG 4/5/6.4.24 Sepsis & Septic Shock – Adult to Council for approval.
Proposed: Macartan Hughes **Seconded:** Shane Mooney
Carried without dissent

Resolution: That the Medical Advisory Committee recommend CPG 5/6.7.34 Septic Shock – Paediatric to Council for approval.
Proposed: Shane Mooney **Seconded:** Mick Molloy
Carried without dissent

3.5 Stridor Paediatric CPG

Brian Power and Stanley Koe reviewed and amended draft CPG 4/5/6.13.9 Stridor – Paediatric, as included in the meeting papers. Identifying the signs associated with mild, moderate, and severe croup was discussed. It was stated that signs of croup are part of a spectrum and some children presenting with croup won't have all the symptoms. It was agreed to amend the list of severe and moderate signs of croup and include; 'if symptoms are persistent treat as severe croup' and 'if symptoms are intermittent treat as moderate croup'. A document from the Royal Children's Hospital Melbourne, which breaks down mild, moderate and severe croup, using a simple table format, was referenced.

Following discussion, further amendments were agreed to the Stridor Paediatric CPG and Brian Power made the amendments accordingly.

- Add 'Consider' before 'Humidified O_2 – as high a concentration as tolerated ' and make this a non-core element - move 'Oxygen therapy' to after 'Assess & maintain airway'
- Following 'Do not insert anything into the mouth (other than PO medications)' add 'for croup' so that it reads: 'Do not insert anything into the mouth (other than PO medications for croup)'
- Severe croup may include:
  - Following 'Hypoxia' add '/cyanosis'
  - Add 'Marked' before 'respiratory distress'
  - Delete 'at rest' after 'Stridor'
  - Replace 'Moderate Croup; Stridor or chest wall indrawing at rest without agitation' with 'If persistent treat as severe croup. If symptoms are intermittent treat as moderate croup'
- Add new box; 'Maximum Dexamethasone administered within the past 72 hours not to exceed 600 mcg/Kg'
- Delete diamond – 'Moderate croup'

Subsequent to discussion, the following resolution was passed.

Resolution: That the Medical Advisory Committee recommend CPG 4/5/6.13.9 Stridor – Paediatric to Council for approval.
Proposed: Stanley Koe **Seconded:** Macartan Hughes
Carried without dissent

3.6 Traumatic Cardiac Arrest – Adult CPG

Amended draft CPG 5/6.6.11 Traumatic Cardiac Arrest – Adult was included in the meeting papers for review. Brian Power highlighted the changes and further changes were agreed.

- Add box; 'Consider non-traumatic causes'
- After 'Commence CPR and ALS' add 'Go to appropriate CPG'
- Add 'Pre-alert ED' after the ambulance emoji

Brian Power made the amendments as agreed.

Subsequent to discussion, the following resolution was passed.

Resolution: That the Medical Advisory Committee recommend CPG 5/6.6.11 Traumatic Cardiac Arrest – Adult to Council for approval. **Proposed:** Eoghan Connolly **Seconded:** Shane Mooney Carried without dissent

3.7 Poisons -Adult

At the May MAC meeting a discussion was had whether there is a requirement for using Activated Charcoal in a pre-hospital environment and it was suggested that up to date data be sourced on the benefits of Activated Charcoal. Activated Charcoal has been included on the Seventh Schedule. Draft Poisons-Adult CPGs with supporting data from Phil Darcy was included in the meeting papers for further review.

A discussion ensued. It was stated that activated charcoal has been shown to be useful and not harmful and should be considered for use in a pre-hospital environment. It was noted that activated charcoal is included in the JRCALC Guidelines and NICE Guidelines. A member questioned whether activated charcoal is clinically appropriate as there is not enough evidence to support its use and it is very rarely used. The Chair read out a list of benefits of activated charcoal which was reviewed and discussed at the May MAC meeting.

Consideration was given as to whether Activated Charcoal should be a core or non-core element of the Poisons CPGs and the members voted on this. As a result, the Committee agreed to make Activated Charcoal a non-core element. It was agreed to add 'Consider' before 'Activated Charcoal, 50 g, PO'.

Subsequent to discussion, the following resolution was passed. Niamh Collins noted her dissent stating that she did not have enough information to make a decision.

Resolution: That the Medical Advisory Committee recommend CPGs 4/5.4.22 and 6.4.22 Poisons - Adult to Council for approval subject to the changes agreed. **Proposed:** Mick Molloy **Seconded:** Shane Mooney **Carried with dissent. Niamh Collins dissented.**

4. Clinical Developments

4.1 Seventh Schedule

4.2 Tenth Schedule

Updated LEG004 – Medicinal Products Seventh Schedule and LEG018 Medicinal Products Tenth Schedule were included in the meeting papers for information. Brian Power informed the members that both Schedules are stored in the PHECC Quality Management System and will be updated as required. The DoH decision to remove paediatric administration of Methoxyflurane pain from the Seventh Schedule and to limit the administration to adults for traumatic pain has highlighted that the process needs to be tightened up. The Chair and PHECC Director are engaging with the DoH on the matter.

4.3 Refusing treatment and/or transport

Draft PHECC Standard on Refusal of treatment and/or transport was included in the meeting papers for review. Brian Power provided an overview. He advised that there is no current standard in place and PHECC practitioners are requested by their respective Licensed CPG Providers, to 'encourage' patients that refuse treatment and/or transport, to accompany them in the ambulance to an emergency department. There is no clear guidance on a process or procedure for such patients. Ireland is the exception in this regard as all other western jurisdictions have such a standard in place. The Committee thanked Brian, acknowledging the work he has done, and noted the importance of having a standard for refusal of treatment and/or transport. Following discussion it was agreed that further review and discussion is required. It was agreed to circulate the draft standard to the Quality and Safety Committee and request their input. The Chair requested that any feedback from MAC members be sent to him prior to the July MAC meeting.

Copy of correspondence from the Chair of the Quality and Safety Committee to the Chair of MAC regarding the Palliative Care CPG was included in the meeting papers. At the June meeting of the Quality and Safety Committee the HSE Palliative Care Competence Framework was discussed in terms of the quality of care delivery to palliative care patients by PHECC practitioners. During discussion it was highlighted that palliative care is a clinical presentation that is encountered, all be it on an irregular basis, by PHECC practitioners responding to a 112 emergency. In the absence of the Palliative Care CPG being implemented by both statutory ambulance services, the Quality and Safety Committee feel that this cohort of patients are not being offered the optimum level of care. The Quality and Safety Committee is, therefore, requesting that the Medical Advisory Committee change the designation of the Palliative Care CPG from a non-core to a core CPG in the interest of patient care quality.

The Chair of the Quality and Safety Committee relayed that correspondence was also sent to the two statutory service providers requesting what issues, if any, exist which prevent them from implementing the Palliative Care CPG, and seeking data on the number of and percentage of the total 112 patients, designated as palliative care patients, by their practitioners during 2019. There has been no response to date from NAS and DFB to this request.

A discussion ensued. It was stated that the Palliative Care CPG may not be relevant to all voluntary and private Licensed CPG Providers, and the statutory service providers have a different patient cohort. It was noted that the Quality and Safety Committee have recommended to the Palliative Care Framework Programme that PHECC practitioners should be on the Palliative Care Framework at levels 1 and 2. It was suggested that the Palliative Care CPG might be best placed with the Community Paramedic. Brian Power advised that the Palliative Care Programme and Irish College of General Practitioners have endorsed the Palliative Care CPG. He stated that palliative care patients are a very vulnerable group of patients who may wish to die at home with dignity and it is wrong that practitioners must encourage them to go to hospital.

Following discussion it was agreed that; the Chair will write to the Medical Directors of NAS and DFB seeking information, as per request from the Quality and Safety Committee, in order to establish a way forward; the Chair will engage with and seek advice from the Palliative Care Framework.

5. Clinical Queries

5.1 Paediatric defibrillation

At the May meeting amendments were agreed to POL036 Pre-Hospital Defibrillation Position Paper. Amended draft POL036 was included in the meeting papers for approval. Brian Power highlighted the changes.

Subsequent to discussion, the following resolution was passed.

Resolution: That the Medical Advisory Committee recommend POL036 Pre-Hospital Defibrillation Position Paper to Council for approval. **Proposed:** Stanley Koe **Seconded:** Macartan Hughes Carried without dissent

6. Correspondence

6.1 Medications and Pregnancy Identification on CPGs

Following discussion at the May meeting it was agreed to look at different design options for medications and pregnancy identification on CPGs. The members were requested to forward ideas to Brian Power for consideration. Brian relayed that he did not receive any feedback. Two examples of the Allergic Reaction/Anaphylaxis – Adult CPG showing a pregnancy risk indicator, as a red P within a red circle, were provided in the meeting papers for further consideration, one CPG with a single risk indicator at the top, and the second with the risk indicator attached to each relevant medication within the CPG.

Both examples were considered, and the members voted. As a result, the Committee agreed that the pregnancy risk indicator for medications where contra-indicated for pregnancy will be placed at the top of the CPGs.

Subsequent to discussion, the following resolution was passed.

Resolution: That the Medical Advisory Committee agree that the pregnancy risk indicator for medications where contra-indicated for pregnancy is to be located at the top of CPGs. **Proposed:** Mick Molloy **Seconded:** Macartan Hughes Carried without dissent

7. MAC Strategy 2017-2020

7.1 Community Paramedic (CP)

Hillery Collins, Chair of the Community Paramedic subgroup, provided an update. He will circulate a draft report to the subgroup for feedback. A subgroup meeting will be convened via video conference and an invitation to join the meeting was extended to the members. The final report will be presented at the July MAC meeting.

7.2 Critical Care Paramedic (CCP)

An update will be provided at the July MAC meeting.

8. Clinical Practice at Events

9. External communications, consultation, feedback

There was no update for these agenda items.

10. AOB

The Chair addressed the meeting. Brian Power is due to retire on 30th June 2020 and this is his final MAC meeting. The Chair, on behalf of the Medical Advisory Committee, presented a departing gift to Brian. The Chair extended his heartfelt thanks to Brian and expressed the sentiments of the Committee, that Brian will be greatly missed and his departure from PHECC will be a huge loss to the MAC, PHECC, and the wider pre-hospital emergency care industry. The Committee members thanked Brian for all his hard work, dedication, and commitment over the years and wished him well for the future.

The meeting concluded at approximately 3pm.

The Chair thanked everyone for attending. The next MAC meeting will be held on Thursday 30th July.

Signed: _____ **Date: 27th August 2020**

Chair