Medical Advisory Committee

Meeting Minutes

29th November 2018, PHECC office @ 10:00am

Pre-Hospital Emergency Care Council

Present	Apologies	In attendance
David Menzies (Chair)	Shane Knox	Richard Lodge, PHECC Director
David Irwin (Vice Chair)	Peter O'Connor	Brian Power, PHECC PDO
David Hennelly	Lisa Cunningham Guthrie	Ray Carney, PHECC PDO
Ian Brennan	Philip Darcy	Ricky Ellis, PHECC PDO
Shane Mooney	Gerard Bury	Kathleen Walsh, PHECC PDO (Agenda item 4.2 and 4.4 only)
Stanley Koe		
Cathal O'Donnell	**Absent**	Margaret Bracken, PHECC Support Officer
Martin O'Reilly	Mark Dixon	Paul Butcher, Dublin & Wicklow Mountain Rescue Team, (Agenda item 4.4 only)
Hillery Collins		
Eoghan Connolly		
Niamh Collins		
Macartan Hughes		
Jason van der Velde (t/c)		
Mick Molloy (t/c)		

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1. Chair's Business

The Chair welcomed everyone to the meeting. Apologies were noted. The Chair welcomed the recently appointed PHECC Director, Mr Richard Lodge, to the meeting and introductions were made by the members. Mick Molloy and Jason van der Velde attended the meeting via teleconference. The Chair informed the members that Stanley Koe, David Irwin and Macartan Hughes, would be arriving late. Condolences were expressed to Brian Power on the death of his mother and to John Lally, PHECC IT Officer, on the death of his brother in law.

The Chair informed the members of a change in the sequencing of the agenda. Agenda item 4.4 with presentation from Mr Paul Butcher, member of Dublin & Wicklow Mountain Rescue Team, to follow on after agenda item 3.1. Agenda items 4.3, 8.1 and 3.2 were discussed in that order following agenda item 4.4 to facilitate Mick Molloy who had to attend another meeting.

2. Minutes from September 2018 meeting

The minutes of the meeting held on 27th September 2018 were reviewed. Some amendments were highlighted and agreed by the members.

- Martin O'Reilly requested that the wording in agenda item 3.3 Pre-eclampsia be amended from "was told all was fine and sent home" to "and was subsequently discharged".

- Niamh Collins requested the following:
  - agenda item 5.2 paediatric intubation; "anaesthetising a paediatric versus intubation" be amended to "anaesthetising versus intubating a paediatric".
  - agenda item 8.1 Strategic Development Committees; the word 'relating' be amended to 'requesting' "The email was sent on 31st July requesting that members of the Committee should contact the working group Chair".
  - The naming convention be standardised throughout the minutes.

- Cathal O'Donnell requested that the wording in agenda item 9 with reference to the new Helicopter Emergency Medical Service in Cork, be amended to "Cathal O'Donnell advised that in his opinion this was outside the scope of the Medical Advisory Committee".

Resolution: That the Medical Advisory Committee approve the minutes of the meeting held on 27th September 2018 subject to the agreed amendments.

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

2.1 Matters Arising

Agenda item 3.3 Pre-eclampsia
Niamh Collins noted her reservations regarding the use of slow acting Nifedipine for pregnancy. She stated there would be no value in the use of slow acting Nifedipine. Brian Power advised that the medication formulary specifies normal preparation of Nifedipine for pregnancy.

Agenda item 4.2 Letter to RSA
The Chair requested an update regarding a proposed meeting with PHECC and the RSA to discuss future collaborations. Ricky Ellis, PHECC Programme Development Officer, informed the members that communication had been initiated by PHECC and a meeting was suggested and agreed. PHECC are awaiting the RSA to propose a meeting date following on from the last communication.

3. Clinical Queries

3.1 ROSC CPG

An email request to amend CPG 5.6/4.7 Post Resuscitation Care-Adult was submitted from a NAS post graduate intern paramedic for consideration of the MAC and included in the meeting papers. As part of the student's learning portfolio he wanted to identify a CPG that could be developed and believes that CPG 5.6/4.7 should state that after ROSC and a reliable $Sp0_2$ attained, oxygen should be titrated to achieve an $Sp0_2$ of 94-98%, rather than the continuation of 100% oxygen therapy as is currently stated. A supporting literary review was submitted outlining the evidence and a reason the CPG should be changed.

Shane Mooney stated that this is a training issue and oxygen therapy is covered during upskilling. The members discussed the implications for CPG changes at this stage. It was noted that following publication of the 2017 Edition CPGs the MAC agreed that unless there was a patient safety issue any changes recommended would be included in a supplement issue later in the year or early the following year. Niamh Collins stated that this was reflected in previous CPG changes and it is a different situation to oxygen therapy. She stated that she does not see a requirement at present to amend the current CPGs. The consensus among the members was that there is no immediate patient safety issue and the Post-Resuscitation CPGs will be reviewed with the next revision of CPGs in 2019.

David Hennelly suggested amending the medication formulary for now. Ray Carney suggested the upcoming field guide app could provide information in the interim. The members agreed with both suggestions.

* David Irwin and Stanley Koe joined the meeting.

Resolution: That the Medical Advisory Committee agree that the medication formulary and field guide app be amended to state that after ROSC and a reliable $Sp0_2$ attained, oxygen should be titrated to achieve an $Sp0_2$ of 94-98%. The current Post-Resuscitation Care CPGs for practitioners and responders will be amended with the next review of CPGs in 2019 to reflect this.

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

3.2 Concussion

An email request to develop a new CPG for concussion from a nurse/physical therapist and PHECC registered EMT, who provides physio cover for GAA and rugby clubs, was included in the meeting papers for consideration.

Shane Mooney advised that a CPG for concussion is not warranted. Mick Molloy concurred and stated that it is not part of the remit of nurses and physical therapists to assess concussion with a view to return to play. Niamh Collins stated that if a patient has symptoms of concussion an assessment needs to be carried out which is not addressed in the current CPGs. She suggested listing the symptoms which may indicate concussion to the head injury CPGs and advise to seek medical assistance. Ray Carney stated that the responder CPGs are not adequate to address this issue, and an education piece is needed. Shane Mooney stated that there is ample education material available and there are no circumstances where practitioners should assess concussion to make a return to play decision.

Cathal O'Donnell stated that a CPG for concussion requires consideration. He noted that the GAA and IRFU have very good, although different, education packages. He stated that issues arise for practitioners attending matches, where injured players want to continue playing and refuse to go to hospital. The question is, in what circumstances can practitioners say to an injured player with a suspected concussion that they can continue playing. Brian Power advised that it is not in a practitioner's remit to state to a player that they can go back on the pitch and continue playing.

Hillery Collins suggested adding concussion under a consideration for seizures and convulsions to the head injury CPG. Brian Power noted that practitioners are attending matches to provide assistance and, usually, teams have their own doctor or physiotherapist available to team members. He stated that he does not see a requirement for a concussion CPG, but a stronger education piece could be supported. Cathal O'Donnell advised that doctors are present at the higher-level matches but not at underage level. He suggested referring this matter to the treat and refer subgroup.

Martin O'Reilly stated that a medical practitioner is the only person qualified to make an assessment on concussion. Shane Mooney noted that in rugby there is the potential of three concussions per team per season. Ricky Ellis raised the possibility of PHECC creating a stand-alone education piece based on what is known from research and implemented by individual sports to date. This educational piece could be made available to all stakeholders in all sports nationally as an eLearning module via the PHECC website, this would support PHECC's remit to provide standards to protect the public. The Chair suggested engaging with the Sports Council and other sports bodies to raise the level of awareness about concussion. Mick Molloy noted that this could link in with the Faculty of Sports Medicine.

The Chair agreed that there is merit in developing an education piece on concussion and possibly including concussion as a treat and refer CPG for the future. It was agreed that the Chair will write to the Chair of the Education and Standards Committee regarding the inclusion of concussion in the education and

training standards. It was agreed that Shane Mooney, Ray Carney and Mick Molloy will work together on a position paper for concussion. The Chair and Ray Carney will respond to the nurse/physical therapist and provide clarification. Shane Mooney stated that the concussion recognition tool agreed worldwide is current best practice, which all sporting bodies adhere to, and he suggested referring to this in the response to the nurse/physical therapist.

Resolution 1: That the Chair of the Medical Advisory Committee will write to the Chair of the Education and Standards Committee regarding the inclusion of concussion in the education and training standards.

Proposed: Macartan Hughes **Seconded: David Irwin**
Carried without dissent

Resolution 2: That the Medical Advisory Committee agree to develop a position paper on Concussion.

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

3.3 Frequency of side effects (medication formulary)

An email from a practitioner regarding Methoxyflurane et al with a request to include the frequency and severity after key side effects, also include the word temporary in the SE box was included for consideration. The members directed Ray Carney to respond and refer the practitioner to the HPRA website for information regarding this.

3.4 PPH and Breech CPGs

An email from Senior Fellow, Paramedic Studies, UL Graduate Entry Medical School, regarding PPH and Breech CPGs was included in the meeting papers for consideration. Two midwifery tutors, enlisted to deliver sessions on antepartum and post-partum emergencies to first year BSc students, identified issues with the CPGs.

CPG 4/5/6.5.4 Postpartum Haemorrhage and CPG 5/6.5.6 Breech Birth, and extracts from HSE/RCPI Institute of Obstetricians & Gynaecologists, were also included in the meeting papers. Ray Carney informed the group that he has sought advice from Prof Mary Higgins, UCD Obstetrics and Gynaecology clinical programme, who suggesting requesting evidence from the correspondent. Macartan Hughes noted that the JRCALC guidelines reflect these concerns regarding breech birth. Niamh Collins stated that the breech birth CPG needs to be revised. David Irwin noted that the CPG starts late in the process which is an issue. Hillery Collins proposed that PHECC make a further request to Prof Higgins for advice.

Brian Power advised that Prof Higgins approved all of the current gynaecology/obstetrics CPGs. David Hennelly suggested that the gynaecology/obstetrics CPGs be reviewed in consultation with the experts in this area. Hillery Collins proposed that Niamh Collins take the lead on this review and Niamh accepted. She sought volunteers from the members to join her and meet with Prof Higgins. Hillery Collins, Martin O'Reilly, Macartan Hughes and Brian Power put themselves forward. An update will be provided at the March 2019 MAC meeting. The Chair suggested inviting Prof Higgins to attend a MAC meeting early in 2019.

3.5 Tachycardia CPG

A query from a practitioner regarding the Tachycardia CPG was included in the meeting papers. The practitioner raised concern that the CPG still seems unclear on how to progress a patient who is showing adverse (unstable) signs but is not unresponsive. He stated that ACLS guidelines advocate immediate synchronised cardioversion with sedation if necessary which he cannot do. He stated that during the CPG upskilling the option of telephone support was discussed. He queried could this be added to the CPG with a link back to Valsalva where possible, but no adenosine (as unstable). CPG 5/6.4.12 Tachycardia – Adult was included.

David Irwin stated that a full review of the tachycardia CPG is required. He noted his concerns and pointed out that a review of the tachycardia CPG was discussed at a previous MAC meeting and needs to be addressed again. He suggested that the practitioner be responded to, thanked for his concern, and informed that the tachycardia CPG is currently under review, and that his upskilling is correct as it is a medical case by case basis. It was noted that CPGs currently under review are tachycardia, gynaecology/obstetrics, cardiac/stroke, sedation and treat and refer. It was further stated that the next suite of CPGs will be agreed in 2019 for publication in 2020.

The members discussed a schedule for the review and release of the next edition of CPGs. Hillery Collins noted that it was suggested at a previous MAC meeting that draft CPGs be circulated to licensed CPG providers for feedback prior to final approval, and this needs to be factored in. Brian Power advised that following approval of the CPGs the medication formulary, field guide, education and training standards and examinations material have to be updated. The amount of work this involves needs to be taken into consideration. David Hennelly noted that the new ILCOR guidelines will be released in November 2020. He stated that clinical practice procedures and the structural format of the CPGs need to be addressed.

The members agreed the following schedule for the next edition of CPGs:

1. Final Draft CPGs - June 2019 MAC meeting.
2. Stakeholder consultation with recognised institutions and licensed CPG providers - prior to the September 2019 MAC meeting.
3. Structural format of CPGs to be decided prior to the September 2019 MAC meeting.
4. Final CPGs to be approved - September 2019 MAC meeting.
5. New edition of CPGs to be published - Spring 2020.

Martin O'Reilly suggested engagement with the stroke unit and Brian Power suggested contacting the trauma network. The Chair proposed contacting Prof Rónán Collins, Director of stroke services, Tallaght Hospital for input.

3.6 Naloxone for neonates

An extract from the JRCALC Clinical Practice Guidelines from the Association of Ambulance Chief Executives on 'Naloxone Hydrochloride: indication to reverse respiratory and central nervous system depression in a neonate following maternal opioid use during labour removed' was included in the meeting papers.

Ray Carney informed the members that Prof Tony Ryan has retired from the NRP Programme and has not been replaced yet, and no advice has been received from the NRP. Stanley Koe advised that Naloxone exacerbates withdrawal symptoms and has been written out of neonatal policies. He stated that the main focus with neonates when delivered is to provide adequate oxygenation. The Chair asked if there is an immediate safety concern requiring that the CPG be amended prior to the full review of CPGs in 2019. The consensus was that it is rare that neonates are administered Naloxone, there is minimal risk and an

immediate safety concern cannot be identified. It was suggested to consult with Prof Mary Higgins, UCD Obstetrics and Gynaecology clinical programme, and review Naloxone for neonates with the PPH and Breech CPGs, as previously agreed.

Resolution: That the Medical Advisory Committee agree that there is minimal risk in administering Naloxone for neonates and it does not impose an immediate risk to patient safety. The neonate CPGs will be reviewed with the next suite of CPGs in 2019.

Proposed: Hillery Collins **Seconded: Stanley Koe**
Carried without dissent

3.7 Aspirin in pregnancy

PHECC recently reviewed all the medications available to its practitioners in relation to their administration to pregnant patients. This process was completed following consultation with Muriel Pate, Medication Safety Specialist Pharmacist, HSE, and has been published on the PHECC website.

Following a query to the MAC on 'Aspirin administration during pregnancy by EMTs and responders' it was decided to seek advice from both the ACS and the Obstetrics and Gynaecology clinical programmes, and the HSE Senior Pharmacist, to help clarify the matter. Advice received from Prof Mary Higgins, UCD Obstetrics and Gynaecology clinical programme, and Muriel Pate, was included in the meeting papers. Ray Carney informed the group that no definitive response has been received from the ACS clinical programme. Prof Higgins advised that she considers it negligent not to give Aspirin to a pregnant woman with chest pain as cardiac disease is the leading cause of maternal death with minimal risk of foetal issues. Muriel Pate advised that the recommended dose of 300mg for cardiac chest pain as stated in the CPGs exceeds what is typically accepted to be safe in normal circumstances. She stated that she is more than happy to discuss the matter further.

A discussion followed on whether EMTs and responders should routinely administer Aspirin to pregnant patients with suspected cardiac chest pain in the absence of a 12 lead ECG, or should pregnancy be a contraindication for Aspirin in the absence of an identified STEMI. Currently only Paramedics and Advanced Paramedics have 12 lead ECG acquisition within their scope of practice.

Following discussion, it was agreed to amend the medication formulary for Aspirin and amend the CPGs when the next batch of CPGs are reviewed in 2019.

Resolution: That the Medical Advisory Committee agree that the medication formulary for Aspirin be amended to include pregnancy as a contraindication except at Paramedic and Advanced Paramedic levels where there is suspected cardiac chest pain.

Proposed: Cathal O'Donnell **Seconded: Eoghan Connolly**
Carried without dissent

4. Correspondence

4.1 Report to OHCAR steering Group on ERC Conference Bologna Sept 2018

Report to the OHCAR Steering Group on the European Resuscitation Council Conference, Bologna, Italy, 20th - 22nd September 2018 was included in the meeting papers for information. The Chair stated that it

was noted at the November Council meeting that this is a good initiative being supported by PHECC and the NAS.

* Kathleen Walsh, PHECC PDO, joined the meeting for agenda item 4.2.

4.2 First Aid for Childminders

Childminding Ireland Executive has sought PHECC guidance and support for developing a bespoke first aid course targeted to childminders in the home environment, who are currently not regulated. They have submitted a paediatric first aid course proposal to PHECC for consideration. The draft proposal and some notes to advise on previous discussion on this topic were included in the meeting papers.

Kathleen Walsh provided the background. She informed the members that this draft proposal was discussed at length at the Education and Standards Committee meeting on 20th November and it was agreed that the Education and Standards Committee are committed in principle to reviewing and introducing a paediatric first aid module. The Committee requested that Ray Carney bring this issue to the MAC to discuss the clinical issues involved. Ms Walsh noted that there are a significant number of childminders in the country, and PHECC has previously communicated with the Department of Children and Youth Affairs regarding development of a paediatric first aid module.

There was a robust discussion. Niamh Collins advised that there is a need to know where childminders are being trained. The Chair suggested a FAR add on module for paediatric first aid. Brian Power advised that non-PHECC approved childminding courses are being provided with no standard in place. He stated that the FAR course is adequate for the majority of paediatric first aid requirements, however, there is a requirement for a paediatric emergencies module in conjunction with the FAR course. Hillery Collins stated that TUSLA have identified a need for a standard to enforce regulation for childminders and it is PHECC's aim to support and protect the public. Ray Carney noted his concern regarding the additional time required to deliver the training, currently a FAR course is 18 hours. David Hennelly stated that consideration needs to be given to the wider childminding community and this could apply to schools, creches etc. Niamh Collins noted that childminders are often non-Irish in a lot of cases and English may not be their first language, therefore to keep children safe it needs to be simplified.

Ian Brennan noted that the FAR standard covers a lot of the elements proposed by Childminding Ireland and suggested it could be tailored to suit. It was suggested the FAR standard with minimal adjustment could be tailored to cater for paediatric groups, through the creation of a FAR paediatric standard. This standard would be available alongside the FAR adult standard. i.e. two distinct standards, which would cover very similar items albeit as core elements, therefore paediatric FAR would not be a bolt on module added to an adult course. The Director advised that there is a need to regulate this area and we should be considering a module within the FAR. David Hennelly noted that career framework levels were discussed at a previous MAC meeting and he will circulate the career framework model document to the members.

Brian Power suggested a paediatric module which excludes the adult medical emergencies of the FAR course. The Chair questioned whether the FAR course is deficient in paediatrics. Kathleen Walsh advised that TUSLA are enquiring about different content for paediatrics focusing on common childhood conditions of an emergent nature. She advised that PHECC will engage further with TUSLA and the Department of Children and Youth Affairs regarding specific content considerations.

4.3 Medical Practitioners at events from Quality & Safety Committee*

Included in the meeting papers was an extract from Chair approved minutes of the Quality and Safety Committee meeting of 5th October 2018, in which the Chair recommended that the MAC send an advisory letter to the Medical Council regarding the MMA fight which took place in April 2016, and resulted in a fatality, and advising of our concerns and the concerns for the public. Copies of letters dated 11th June 2018 and 28th August 2018 from the Chair of the Quality and Safety Committee to the CEO of the Medical Council seeking clarification and advice regarding medical direction were also contained in the meeting papers.

Ray Carney advised the members that the Quality and Safety Committee have been dealing with this matter. Shane Mooney, Chair of the Quality and Safety Committee, provided some background. He advised that the morning of the Quality and Safety Committee meeting on 5th October a Medical Council representative telephoned the PHECC Registrar and advised on the concept of medical delegation rather than medical direction, and a letter to this effect from the Accreditation Executive of the Medical Council, dated 16th November, was included in the meeting papers. Shane Mooney stated that the letter from the Medical Council does not adequately address the questions which they were asked in the June letters regarding medical direction.

In conversation with the PHECC Registrar, The Medical Council representative stated that they have received no formal notification or complaint concerning the doctors who were involved in the MMA fight. Cathal O'Donnell enquired as to whether PHECC intend making a formal complaint about the doctors in this case. He stated that the complaints procedure is very formal and difficult for the persons involved with life altering consequences for the medical practitioners. He questioned if it is proper and appropriate procedure for PHECC to make a complaint of medical negligence. The Director advised that there is not sufficient information available at present to make a formal complaint to the Medical Council. The Chair advised that this is a matter for Council. He stated that currently there is no set standard for doctors at events.

Mick Molloy noted the seriousness of this case for the deceased and his family. He noted that a litany of issues arose at the coroner's inquest into the MMA fight at which he was present, and it is unsure if the coroner conveyed the result of this case to the Medical Council. He stated that the Medical Council do not see any issue with medical direction and they informed him that they are not obliged to attend inquests. He queried if a fitness to practice case has been made regarding the PHECC practitioner/s involved and Brian Power advised that there are cases pending.

The Chair recommended that the Quality and Safety Committee continue to deal with this matter and seek a meeting with the Medical Council. He suggested that any further correspondence to the Medical Council be sent to the newly appointed Chair of the Medical Council.

* Kathleen Walsh, PHECC PDO, joined the meeting for agenda item 4.4.

4.4 EFR add-on for Mountain Rescue

A proposal from Mountain Rescue Ireland to develop a Mountain Rescue (MR) add on component for the PHECC EFR standard which would enable MR teams trained to EFR level to safely care for their patients while being compliant with PHECC was included in the meeting papers. Mountain Rescue Ireland propose to extend the clinical skill base of the EFR trained rescue team members working in the mountain rescue environment, to offer better clinical treatment in the isolated and sometimes dangerous environments

and situations encountered in mountain rescue. The proposal set out requirements for additional training for EFRs, identified the existing skills gap between EFR and EMT, and listed possible additional skills and medications.

The Chair requested David Irwin, Vice Chair, to chair this agenda item as there was a possible conflict of interest as the Chair is a medical director for a mountain rescue team. The Vice Chair introduced Mr Paul Butcher, member of Dublin & Wicklow Mountain Rescue Team (DWMRT), who presented to the members. Mr Butcher informed the group that DWMRT is a PHECC licensed CPG provider and the aim is to encourage more mountain rescue teams around the country to apply for PHECC approval. He stated that often it is not possible to provide a higher level of care to patients as EFR trained rescue team members working in the mountain rescue environment do not have the required clinical skill base. There was a lengthy discussion with questions and feedback from the members.

David Hennelly noted that the potential need for specialist roles was highlighted and discussed at a previous MAC meeting and could be considered. Niamh Collins suggested an add on module for teams located in remote and austere areas with current competencies legally permitted. Clinical Governance and medical direction was discussed. Martin O'Reilly enquired if Mountain Rescue Ireland have access to medical direction. Also, do they currently operate under SI 449 of 2015 Medicinal Products (Prescription and Control of Supply). It was noted that not all of the medications listed in the proposal are on the tenth schedule. Ricky Ellis asked Mr Butcher whether Mountain Rescue Ireland intend to apply for CPG approval as an umbrella organisation and spoke about the role of the Governance Validation Framework as the PHECC mechanism for ensuring that organisations are providing care based on a quality improvement model. Mr Butcher advised that Mountain Rescue Ireland is an umbrella organisation and that each individual mountain rescue team around the country are an entity in their own right, and currently there is no common agreement on structures or processes. He stated that it was hoped that each mountain rescue team would apply to PHECC for CPG approval.

Kathleen Walsh queried if there is any uptake for the PHECC CFR/MLO courses and Mr Butcher stated that some of the teams currently have CFR certification and some are in the process of recertifying. Brian Power advised that Dublin & Wicklow Mountain Rescue Team, and Glen of Imaal Mountain Rescue Team which is a branch of the Irish Red Cross, are the only teams licensed with PHECC at present. He stated that it is PHECC policy not to recognise non-PHECC qualifications and that RPL could be considered. He noted that the availability of medications is very important but there are legal constraints involved. David Hennelly suggested that rather than every individual mountain rescue team, some of which are small groups of volunteers, seeking RPL, PHECC could consider this in its entirety. Mr Butcher stated that rescue teams are more than willing to engage with PHECC.

Hillery Collins stressed the importance of developing a strong education process and recommended this be referred to the Education and Standards Committee. He enquired from Mr Butcher if Mountain Rescue Ireland have consulted with other PHECC licensed CPG providers and Mr Butcher confirmed that they have. Hillery Collins stated that the remote Islands are provided with additional training. Eoghan Connolly suggested that the BTEC module be considered for remote and austere environments without the need for developing new CPGs. The Chair noted that BTEC was originally only made available to the Gardaí and suggested amending the BTEC module for the mountain rescue environment. He advised that clinical governance must be carried out in a correct manner. Niamh Collins advised that the environments the Gardaí operate in are very different from those of the mountain rescue teams.

* Macartan Hughes joined the meeting.

David Hennelly stated that certain patients have certain injuries who are out of reach of hospitals. He questioned from a training position how much should be added on to the current BTEC module. Ian Brennan advised that there is a danger of EFR becoming an EMT module if too much is added on and suggested expanding the BTEC module. Jason van der Velde questioned if teaching could be improved and noted the excellent approach and complex skills of the RNLI. Kathleen Walsh informed the group that a tender has been recently submitted for revision of the education and training standards and there is a specification for aligning the CPGs with the education and training standards. She suggested that a standard and CPGs for remote and austere areas could possibly be explored as part of this review for future development.

Cathal O'Donnell commended Mr Butcher on an excellent presentation which he stated was very positive. He commended the mountain rescue teams on the excellent service they provide. He suggested PHECC and Mountain Rescue Ireland collaborate, and an efficient way forward could be to adopt a phased process, identifying the big impact items that don't require a lot of training but have a big impact on patients, and identifying the small things that are relatively straight forward.

Brian Power highlighted the legal issues and stressed that not all members of MRI want to engage in clinical care and that not every team member needs to be trained to a higher clinical level. He stated that PHECC have removed as many barriers as possible and most groups could come under SI 449 and be registered with the HPRA. PHECC have been as supportive as possible and if each team had only one PHECC registered EMT this would give legal authority to hold and access medications and provide legal governance. He stated that PHECC can decide the clinical level and he suggested the level of Rescue-EMT on the PHECC register could be explored as a level on the EMT division. This would mean that mountain rescue teams would have to be PHECC approved. Cathal O'Donnell stated that there are PHECC registered practitioners with MRI, and if MRI apply for CPG approval this would allow existing practitioners more scope.

The Vice Chair suggested that MRI and not every individual rescue team be certified. He stated that it is admirable that MRI want teams to be PHECC approved and they have highlighted a need for it. He suggested a subgroup of the MAC be set up for the development of a module for remote EFR. The Chair of MAC, Brian Power, Ricky Ellis, Mick Molloy and Eoghan Connolly volunteered to join the subgroup. Brian Power advised that Paul Butcher would add considerably to this subgroup, this was accepted by the members. The subgroup will report back at a future MAC meeting.

Kathleen Walsh suggested that the Education and Standards Committee and the Medical Advisory Committee work together to develop an EFR remote level module. The MAC agree in principle to develop a framework to support mountain rescue teams and recommend that the Education and Standards Committee develop the scope of practice within Irish law.

The Chair and the members thanked Mr Butcher.

Resolution: That the Medical Advisory Committee agree the formation of a subgroup, comprising of the Chair, Mick Molloy, Eoghan Connolly, Brian Power, Ricky Ellis, and Paul Butcher of Dublin & Wicklow Mountain Rescue, for the development of an add on component for the PHECC EFR standard for remote environments.

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

* Kathleen Walsh left the meeting.

4.5 Nyxoid dosage

A request from a supplier to consider the inclusion of a pre-filled 1.8 mg dosage of IN Nyxoid (Naloxone) in the CPGs was included in the meeting papers. Currently the CPGs only refer to usage of 0.8 mg of INN which would exclude Nyxoid from use by practitioners. Ray Carney informed the members that he received an email from the DoH who have indicated they will be adding this dosage and route to the Tenth Schedule of SI 449. The Chair questioned would it be favourable to amend the SI to enable this route to be used. Kathleen Walsh noted that this would be a great advantage as there is very little uptake for CFR/MLO for Naloxone. Brian Power noted that the DoH are not specifying a brand, but they are specifying a dose and a route. The Chair stated that the CPG would need to be amended and a dose range added.

Kathleen Walsh questioned if there is a suggestion that training is required for both methods of administration. The Chair advised one method of administration. Ray Carney noted that the education piece will need to be very strong.

It was agreed to amend the CPG to allow IM or IN (for IN specify dose and range) 0.4 mg – 2 mg (max volume per dose not to exceed 2 mg).

Brian Power will amend the CPG as agreed by the members and a revised and amended draft CPG will be included for consideration at the next MAC meeting.

5 MAC Strategy 2017-2020

5.1 Strategic Development Committees

Hillery Collins informed the members that the community paramedic subgroup held a meeting the previous day and an update will be provided at the next MAC meeting. Brian Power reported that Martin O'Reilly is the only MAC member who has expressed an interest in the treat and refer subgroup. Ian Brennan, Hillery Collins and Shane Mooney volunteered to join the treat and refer subgroup. Ian Brennan provided an update on the critical care subgroup. He noted that this will be a two-tier process and there will be engagement with stakeholders. He informed the members that the subgroup held a meeting a couple of days previous and identified a need to develop a document for critical care paramedic and include scope of practice. He noted that governance issues need to be considered and the Education and Standards Committee will need to be consulted. He stated that it is a big body of work but very important to do. Ricky Ellis advised on the necessity for PHECC to create a framework within the specialist areas that will also support the operational side. He suggested that the standards development framework that had been shared by the Canadian Community Paramedic development group could be consulted as a guide during the development of new PHECC programmes. He acknowledged the development work that has already been done within the NAS related to community paramedicine and suggested that this work be acknowledged by the MAC. MAC members present agreed to acknowledge the NAS community paramedic programme.

Jason van der Velde advised that he is working on definitions for the different levels, and he informed the members that he is developing an interim document to define needs, which he will circulate to the members. The Chair presented the interim document to the members. Niamh Collins advised that it has taken the hospitals a long time to become familiar with EMT, P and AP and cautioned against causing more confusion with more definitions for different levels. Jason advised that there is a need to clearly define

clinical levels at scene. The Chair suggested that Jason circulate the interim document to the PHECC Committees for their feedback and table the document for the next MAC meeting.

6 Clinical Developments

6.1 Oxygen therapy guidelines

A BMJ article 'Oxygen therapy for acutely ill medical patients: a clinical practice guideline' was included in the meeting papers for information.

6.2 CPP/CPG – IO access & analgesia

Following discussions at the MAC September meeting the options of amendments to CPGs and the development of a Clinical Practice Procedure were discussed. A listing of all CPGs where IO access is indicated, CPGs where access is indicated as IV only, a sample of an adult and paediatric CPG for discussion on information required on the CPG, and a clinical practice procedure for discussion on concepts and content were included in the meeting papers. Brian Power developed the clinical practice procedure and Ray Carney drafted the CPGs. The Chair thanked Brian and Ray.

The members discussed, and suggestions were made. As agreed amendments will be made by Brian and Ray and updated draft procedure and CPGs will be included for review at a future MAC meeting.

* Macartan Hughes left the meeting.

6.3 Subcommittee report – Sedation

There was no update on this agenda item.

7 CPG Development Process

7.1 FAR CPGs*

A proposal was discussed at the September MAC meeting to separate FAR CPGs from the Responder CPGs. Following suggestions and agreement from the members revised and amended draft CPGs were included in the meeting papers for approval. Ray Carney highlighted the changes to the members.

The Chair enquired as to when the FAR CPGs will be published, and Brian Power advised they will be published following Council approval at their December meeting.

Resolution: That the Medical Advisory Committee recommend the suite of FAR CPGs to Council for approval.

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

7.2 Pain Management – Ketamine*

Following discussion at the September MAC meeting the members agreed to change the dosing regime of Ketamine from 0.1 mg/kg to 0.1 mg/kg - 0.3 mg/kg at 10 minute intervals prn. Revised and amended

draft CPGs 4/5/6.2.6 Pain Management – Adult and 4/5/6.7.5 were included in the meeting papers for approval.

Following discussion, further amendments were agreed to the CPGs. it was agreed that Ray Carney, David Hennelly and Ian Brennan will collaborate to discuss Ketamine and the pain management CPGs and the required changes to be made. Amended draft CPGs will be included for the next MAC meeting.

7.3 Core and non-core CPGs

Ricky Ellis noted that the issue of identifying core and non-core CPGs was still unaddressed by the MAC and suggested that he begin the process of capturing the views of the MAC through the completion of an initial electronic survey. The Committee agreed that this would be progressed.

8 Clinical Practice at Events

8.1 Clinical Care at Events Subcommittee

Council at their July meeting agreed to provide funding to employ a data inputter on a temporary contract as requested. The Chair requested an update. Mick Molloy informed the members that a data inputter has not been advertised yet. Ray Carney advised that appointment of a data inputter has been postponed to January 2019.

Ray Carney informed the members that a further request for de-identified data from licensed CPG providers who provide clinical care at events was circulated to nine licensed CPG providers, of which two have indicated willingness, and one agreed to provide data to a limited extent.

A concern raised by a PHECC AP was included for information and discussion. The practitioner recently attended an incident at an ice rink where a teenager had fallen hard on the ice and had a bump on the back of her head, was nauseous and concussed. The practitioner spoke to a member of staff at the event and enquired who their medical services provider was. He was told that they use a group of independent people. The practitioner is concerned that the individual people providing the cover at the ice rink did not appear to be practicing on behalf of a PHECC licensed CPG provider. The issue of liability for practitioners practicing for non-approved CPG providers was raised.

Ricky Ellis followed up on PHECC's behalf, a copy of correspondence (13th November) to enquire as to clinical cover arrangements at this ice rink event and the response received from the management company of 20th November, were included in the MAC meeting papers. In their response the company stated that they do not employ a care provider organisation and have OFA level qualified first aiders on duty and quoted the HSA requirements on safety in the workplace. The first aid cover was quoted as a requirement of their insurance conditions and what they would consider "best practice" in the skating rink industry given the risk of injury.

Ricky Ellis cited that the lack of a coherent standard related to clinical cover at events prevented PHECC from making any further enquiries, as the promoter was quoting legislation that technically created a situation whereby a first aider was assuming responsibility for injuries that may be serious and are reasonably foreseeable. He advised that into the future an approach is needed where there is an expectation of what level of clinical care should be in place based on an analysis of the common injuries that can reasonably be foreseen.

Ray Carney advised that this case was included to illustrate the need to define the levels of clinical care required at a variety of events and to create a standard based on clinical need. Mick Molloy noted that there is nothing in the CPGs about concussion in these cases. The Chair suggested seeking guidance from the Clinical Care at Events Subcommittee.

9 External communications, consultation, feedback

There was no correspondence for discussion.

10 AOB

10.1 Ray Carney brought to the members attention a DPER circular regarding travel and subsistence costs for employees of public bodies and that PHECC is following its requirements regarding payments for Committee members.

10.2 Ray Carney raised the topic of engagement events for practitioners as previously discussed by the MAC. The Chair suggested a day event at a hotel with presentations and feedback.

10.3 Niamh Collins raised a query on behalf of Macartan Hughes regarding the timeline for the mental health and behavioural CPGs. The Chair advised that these CPGs will be developed between now and June 2019.

The meeting concluded at 16:00pm approximately.

Proposed meeting dates for 2019 will be circulated to members.

Signed: **Chair** **Date:** 7/3/2019