The Medical Advisory Group

Meeting Minutes September 27th 2013

PHECC Office, Naas, Co. Kildare

Present
Mick Molloy (Chair)
Niamh Collins
Macartan Hughes
Derek Rooney
Cathal O'Donnell
Neil Reddy
Martin O'Reilly
David Menzies
Gerry Bury
Dave Irwin
Joseph Mooney
Declan Lonergan
Mick Dineen
David O'Connor
Ken O'Dwyer
Jack Collins
Rory Prevett
Stephen Cusack
David Hennelly
Shane Mooney

Apologies
Seamus Clarke
David McManus
Seamus McAllister
Gerry Kerr
Thomas Keane
Valerie Small
Sean Walsh
Shane Knox

In Attendance
Brian Power
Deirdre Borland
Prasit Wuthisuthimethawee

1. Chair's business

The Chair welcomed the assembled members to the meeting, in particular Dr Prasit Wuthisuthimethawee from Harvard University who was visiting various pre-hospital emergency care facilities within Ireland and was invited to observe the Medical Advisory Committee meeting by the Chair. Apologies received were acknowledged.

A memo from Dr. Geoff King, PHECC Director to committee chairpersons in relation to "Code of Practice for the governance of state bodies" was distributed to those present and read into the minutes as follows:

Code of Practice for the Governance of State Bodies as issued by the Department of Finance

Council has formally adopted and complies with the Code of Practice for the Governance of State Bodies along with the Ethics and Standards in Public Office legislation. The Code of Practice provides a framework for the application of best practice in corporate governance by both commercial and non-commercial state bodies and their subsidiaries.

It is not feasible to have a code of practice which will specifically provide for all situations which may arise. PHECC will take all reasonable steps to ensure that activities comply with the principles of corporate governance. All PHECC Committees should function according to the highest standards of integrity and ethics.

In this respect PHECC Committee members should be advised that;

Members

- *shall as the need arises declare either a direct or indirect interest in any company interacting with PHECC; and*
- *shall absent themselves from the meeting room for any deliberations, vote or decision of the Committee relating to such interests,*

Respect the confidentiality of;

- *the proceedings of Committee meetings*
- *sensitive information and commercially sensitive information (including but not limited to future plans or details of major organisational or other changes)*
- *personal information.*

(Ref - Code of Practice for the Governance of State Bodies as issued by the Department of Finance)

2. Minutes

Jack Collins indicated that there was a typographical error in the minutes and that the discussion regarding 4.1 LT tubes should read “cuffed” rather than “uncuffed” tubes’.

> **Resolution:** That the minutes from the Medical Advisory Committee meeting held on the 27th June 2013 be agreed subject to the changes outlined above.
>
> **Proposed:** Jack Collins **Seconded:** Joseph Mooney
>
> Carried without dissent

3. CPG’s

3.1 Paediatric Bradycardia

Draft CPG 4/5/6.4.9 Symptomatic Bradycardia – Paediatric (≤ 13 years) was introduced by Brian Power for approval. The Committee were asked to give consideration to the necessity or otherwise of splitting the CPG into <8 years and >8 years categories.

The following points were raised;

Dave Hennelly expressed a concern that making an assessment should be based purely clinical presentation and not solely on age. Niamh Collins agreed with this and asked that “if unresponsive and poor perfusion” be added to the decision box. Shane Mooney asked that the phrase “irritability” be removed. There was no agreement to split the age category of the CPG.

> **Resolution:** That the Medical Advisory Committee approve CPG 4/5/6.4.9 Symptomatic Bradycardia – Paediatric (≤ 13 years), subject to the changes outlined.
>
> **Proposed:** Niamh Collins **Seconded:** Macartan Hughes
>
> Carried without dissent

3.2 Post Resuscitation Care – Adult

Draft CPG 5/6.4.14 Post Resuscitation Care – Adult was introduced by Brian Power for approval. He informed the group that the CPG included in the papers included changes requested at the last MAC

meeting he also gave a brief overview of a draft report from Dr Una Geary, Consultant in Emergency Medicine, Chair of the Emergency Medicine Programme regarding the use of therapeutic hypothermia within Irish Emergency Departments. The report indicated that 28 (64%) of hospitals were providing active cooling with their Emergency Departments, five however could not guarantee that cooling could be continued at all times. A discussion ensued on whether or not practitioners should commence cooling if there was no guarantee that the receiving hospital could continue it. The possible risks to the patient should this situation arise were also discussed. Reference was made to the paper from Dr. Conor Deasy, Consultant in Emergency Medicine on therapeutic hypothermia and his support for it in the Irish setting.

Niamh Collins asked that the following changes be made to the CPG; cooling should be one of the latter stages on the CPG, and that more than 500 mL NaCl should be indicated. She also asked that "Symptomatic Bradycardia" be changed to "Symptomatic Arrhythmia" with routes to Bradycardia and V. tachy.

It was deemed that further discussion was warranted and that this CPG should be revisited at a future meeting.

3.3 Pain management – Adult

A draft update of CPG 4/5/6.2.6 Pain Management – Adult was introduced by Brian Power for approval. The group was also asked if Fentanyl should be made available to Adult patients as there were many instances of practitioners seeking medical oversight to do so. David Hennelly suggested that it also be made available for I.V. and I.O access. Stephen Cusack cautioned strongly against this as fentanyl given I.V or I.O has higher instances of causing respiratory arrest than morphine. The Chair suggested that ketamine may be a useful alternative to be made available to the practitioners; he invited David Hennelly to research this and report back to the Committee. It was agreed that in the case on I.N administration of Fentanyl for adults it should read "≥ 16 years" and delete the reference to weight for this group.

> **Resolution:** That the Medical Advisory Committee approve CPG 4/5/6.2.6 Pain Management – Adult subject to the change outlined.
>
> **Proposed:** Mick Dineen **Seconded:** Cathal O'Donnell
> Carried without dissent

3.4 Report from CPG sub group inadequate respiration CPGs

Gerry Bury carried out a presentation on behalf of the CPG subgroup detailing their proposals on the development of CPGs, including drafts of how the group concluded CPGs could be formatted.

Brian Power suggested that a more streamlined way of managing the CPG development process would be for a subgroup to carry out preliminary work and present CPGs to the MAC.

A discussion ensued regarding the scope of MAC regarding the packaging of CPGs. Shane Mooney stressed the importance of utilising technology in delivering CPGs to the practitioner. Stephen Cusack stressed that the role of MAC was to deliver the clinical content of CPGs not to get involved in the packaging and educational aspects of CPGs.

Cathal O'Donnell said that he was under the impression that the subgroup was tasked with reviewing the existing CPGs, in particular the Inadequate Respitations CPG. Gerry Bury offered to continue the work of the sub-group and present draft CPGs to future meetings.

3.5.1 Asthma – Adult AP/P/EMT

Brian Power introduced the draft CPG 5/6.3.4 Asthma – Adult for the Committee's approval. The following changes were suggested. David Menzies asked that the SpO_2 monitor indicator should be move to higher up on the CPG. Brian Power indicated that this was part of the respiratory assessment and that SpO_2 monitoring was an on-going process following the 1st intervention. Niamh Collins asked that IM Hydrocortisone be removed. Martin O Reilly asked that the ambulance graphic on the left be removed. It was also agreed that "go to appropriate CPG" be removed.

Resolution: That the Medical Advisory Committee approve CPG 5/6.3.4 Asthma – Adult subject to the changes outlined.

Proposed: Joe Mooney **Seconded:** Macartan Hughes
Carried without dissent

3.5.2 Asthma Paediatric (≤13 years) AP/P/EMT

Brian Power introduced the draft CPG 4/5/6.7.18 Asthma - Paediatric (≤13 years) for the Committee's approval. The following changes were requested: Change to the same format as the adult asthma CPG. Remove a typo of "repeat x 1". Change the entry point to read asthma/bronchospasm. Remove the reference to Magnesium Sulphate. Remove reference to IM and the reference to 12 years 130 mg dose for hydrocortisone. It was agreed the max does of Hydrocortisone is 100 mg for > 6 years old.

Resolution: That the Medical Advisory Committee approve CPG 4/5/6.7.18 Asthma Paediatric (≤13 years) subject to the changes outlined.

Proposed: Niamh Collins **Seconded:** Mick Dineen
Carried without dissent

3.5.3 Asthma Paediatric (≤13 years) ERF level

Brian Power introduced the draft CPG 3.7.18 Asthma - Paediatric (≤13 years) EFR for the Committee's approval. It was suggested that the entry point be changed from bronchospasm to wheeze, removing the reference to audible wheeze. It was suggested that the words "inhaler" and "own salbutamol" be included to avoid confusion.

Resolution: That the Medical Advisory Committee approve CPG 3.7.18 Asthma - Paediatric (≤13 years) ERF level subject to the changes outlined.

Proposed: David Menzies **Seconded:** David Irwin
Carried without dissent

3.6 Delphi

Brian Power thanked the Committee members who submitted Delphi feedback on CPGs circulated prior to the meeting and stressed the importance of all committee members contributing to the Delphi process. He expressed disappointment with the 57.7% response rate.

3.6.1 Heat Related Emergency – Delphi feedback

Delphi Result: 60% agree; 33.3% disagree

Draft CPG 4/5/6.6.10 Heat Related Emergency – Adult was circulated for Delphi feedback prior to the meeting. David Menzies requested that the reference to 38.8^{o}C be removed and that "Environmental" heat emergency be specified. Niamh Collins asked that the phrase "cool slowly" be included. Neil Reddy asked that the CPG be formatted as per the Asthma CPG into the categories of mild, moderate and severe. David O'Connor asked that the reference to Calcium Gluconate be removed and the volume of fluids be increased to 1L. It was agreed that the patient should not be overcooled. It was agreed that this CPG will be discussed at a future meeting.

3.6.2 Pyrexia Adult

Delphi Result: 73.3% agree; 20% disagree

Draft CPG 4/5/6.4.32 Pyrexia – Adult was circulated for Delphi feedback prior to the meeting. It was agreed to remove reference to IV infusion. A discussion ensued on sepsis in the pre-hospital environment. It was agreed to establish a sepsis sub group consisting of David Menzies, Brian Power, David O'Connor and Joseph Mooney. Denis Daly (AP) will also be invited to join the group as he has conducted a study on the matter. It was agreed that this CPG will be discussed at a future meeting when the subgroup has been formed.

3.6.3 Heat Related Emergency – Paediatric

Delphi Result: 60% agree; 33.3% disagree

Draft CPG 4/5/6.7.20 Heat Related Emergency – Paediatric was circulated prior to the meeting for Delphi feedback. It was agreed to format the lay out as per the Adult Pyrexia CPG and to delete reference to IV fluids and calcium gluconate.

3.6.4 Pyrexia Paediatric

Delphi Result: 66.7% agree; 20% disagree

Draft CPG 4/5/6.7.19 Pyrexia – Paediatric was circulated for Delphi feedback prior to the meeting. Brian Power circulated the recommendations from the NICE regarding administration of antipyretics to under 5 years. The Committee suggested that this CPG be brought back to a future meeting where Sean Walsh was present to give his opinion.

3.6.5. Acute Pulmonary Oedema

Delphi Result: 71.4% agree; 7.1% disagree

Draft CPG 5/6.3.5 Acute Pulmonary Odema was circulated for Delphi feedback prior to the meeting. David Menzies questioned the inclusion of CPAP given the costs and training implications of its introduction. Brian Power outlined the principle of MAC was to consider the patient benefit and costs were a matter for Council and pre-hospital emergency care service providers.

Niamh Collins asked that it be specified to conduct a 12 lead ECG and if STEMI or Non-STEMI are present treat via appropriate CPG. She also asked that if data could be analysed to capture the use of furosemide this could quantify the requirement for CPAP. David Hennelly suggested that IMSCAN could do this and that the centre for pre-hospital research in Limerick could assist with research as there are other potential conditions that may also benefit from the introduction of CPAP/BIPAP. It was agreed to consider CPAP for COPD and asthma. Dr Ciaran Brown's research will be reviewed on this issue. It was suggested that Bradycardia be also considered for this CPG.

3.6.6 Opioid Overdose

Delphi Result: 80% agree; 6.2% disagree

Draft CPG 1.3.2 Opioid Overdose was circulated for Delphi feedback prior to the meeting. Brian Power explained that it is purposed that this CPG would be enacted with the use of an exception register and those permitted to use this CPG must be working on behalf of a CPG approved organisation and authorised to use it. It was envisaged that it would be targeted at health care workers in drug clinics and prisons. PHECC are working with the DoH on the legalities of its implementation. Niamh Collins asked why the patient must be not breathing to receive naloxone; she questioned the merits of teaching naloxone administration and not the skill of assessing a respiratory rate. Gerry Bury informed her that the reasoning was to start with those patients in cardiac arrest and develop the CPG when an evidence base starts to accumulate. It was agreed that the CPG should mirror the BLS CPG as far as possible to avoid any confusion.

Resolution: That the Medical Advisory Committee approve CPG 1.3.2 Opioid Overdose, subject to the changes outlined.

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

4. Practitioner queries re CPGs and medications

4.1 Traumatic Cardiac Arrest

A email query from a practitioner regarding cessation of resuscitation in cases of blunt force traumatic cardiac arrest where PEA was the presenting rhythm was discussed. Niamh Collins cautioned that PEA cases may be resuscitated and rapid transport was required. It was agreed that in such patients in Asystole or who become asystolic may practitioners cease resuscitation.

4.2 IV/IO cannualtion for Paramedics

An email from a practitioner requesting that the skill of IV/IO cannulation be introduced to the Paramedic skills matrix was included in the papers. Brian Power pointed out that such a request had been dealt with previously and that at the time it was agreed that IV and IO access were not the issue but the medication or the fluids infused. Macartan Hughes said that there was little evidence for the benefits of introducing this and the committee agreed to await further developments. A discussion ensued on the benefits of early epinephrine in cardiac arrest. It was agreed to wait until the 2015 ILCOR guidelines emerged to progress further.

4.3 Dilution of drugs in the Pre-Hospital setting

An email from a practitioner seeking guidelines on which fluid to use for the dilution of drugs was included in the meeting papers. The committee agreed that this was a training issue and not in MACs remit. It was agreed however, that water for injection should be the primary diluting agent but that NaCl was safe as a replacement in its absence if not contraindicated.

4.4 Lidocaine 2% as analgesia during the infusion of fluids via IO access

An email from a practitioner requesting the committee consider the introduction of Lidocaine 2% as analgesia during the infusion of fluids via IO was included in the meeting papers. The committee concluded that as IO access is only currently recommended for an unresponsive patient and that this was not merited.

4.5 Abuse and Neglect of Older People in Ireland. 'A National Ambulance Service perspective'

A paper prepared by a practitioner regarding instances of abuse and neglect of older people was included in the meeting papers. Mick Dineen stressed the importance of a pathway being made available for practitioners to report their concern regarding elder abuse in a safe manner. Following a discussion it was agreed that an "older person abuse" guideline similar to the "child first" guideline should be developed. As this is not the remit of the MAC it was agreed to forward the report to Council with recommendations that they would engage with the DoH.

5. Management of Paediatric Diabetic Ketoacidosis

Following a submission from Prof Ronan O'Sullivan to the MAC it was decided to reduce the dose of Sodium Chloride for paediatric ketoacidosis from 20 mL/kg to 10 mL/kg

Resolution: That the Medical Advisory Committee recommend Council to reduce the dose of Sodium Chloride for paediatric ketoacidosis from 20 mL/kg to 10 mL/kg and change the Glycaemic emergency – paediatric CPG accordingly.

Proposed: Stephen Cusack **Seconded:** David Hennelly

6. NHS Pre-Hospital Sepsis Briefing paper

This was included in the meeting papers for the committee's information. It will be considered by the sepsis subgroup.

7. Ticagrelor Medication Formulary Insertion

David Hennelly gave a brief background to the inclusion of Ticagrelor on the medication formulary. Gerry Bury asked that the instances where a GP administers 600mg Clopidogrel for patients presenting with STEMI prior to the arrival of the ambulance be investigated in relation to subsequent administration of Ticagrelor.

Brian Power committed to follow up with the ACS programme and report back to the committee. He will also seek advice on the absolute contraindications of CYP3A4 inhibitors to the administration of Ticagrelor.

8. A.O.B

Declan Lonergan informed the committee that the presentation of buccal Midazolam has changed and it is now available in age specific pre filled syringes rather than weight specific doses. This has implications to the current CPGs. Cathal O'Donnell outlined that the current weight based presentation, is unlicensed by the IMB. The newer age based presentation, although much more expensive is licenced by the IMB. He was advised by the IMB that he would be personally liable if NAS continued to use the unlicensed product. It was agreed that the best solution was to change to age based doses for buccal midazolam.

Resolution: That the Medical Advisory Committee recommend that Council update the seizure – paediatric CPG to incorporate an age based dose of midazolam buccal and remove the weight based dose.

Proposed: David Menzies **Seconded:** Cathal O'Donnell

Signed: ________________________________ Date:____________________