



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

AIRWAY MANAGEMENT TASK FORCE

April 6, 2011--09:00 A.M.

MEMBERS PRESENT

K. Alexander Malone, MD, Chairman, NLVFD
Aaron Harvey, EMT-P, LVFR (Alt.)
Chad Henry, EMT-P, American Medical Response
Chief Bruce Evans, North Las Vegas Fire Dept

Chief Troy Tuke, Clark County Fire Department
Derek Cox, Las Vegas Fire & Rescue
Nancy Cassell, EMS Professor, CSN

MEMBERS ABSENT

Richard Henderson, MD, Henderson Fire Department
Chief Scott Vivier, Henderson Fire Department
Bryan Bledsoe, DO, MedicWest Ambulance

Michele McKee, MD, UMC Hospital
Scott Scherr, MD, Sunrise Hospital

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
John Hammond, EMSTS Field Rep
Judy Tabat, Recording Secretary

Mary Ellen Britt, Regional Trauma Coordinator
Rae Pettie, EMS Project Coordinator

PUBLIC ATTENDANCE

Eric Dievendorf, American Medical Response
Trish Klein, NCTI
Philis Beilfus
Steve Johnson, MedicWest Ambulance
Casey Diamond, NCTI

Mark Calabrese, MedicWest Ambulance
Richard Main, NCTI
Jay McConnell, MedicWest Ambulance
Matt Liguori, American Medical Response

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Airway Management Task Force convened in the Clemens Conference Room at the Ravenholt Public Health Center at 9:10 a.m. on Wednesday, April 6, 2011. The meeting was called to order by Chairman Alex Malone, MD. He stated that the Affidavit of Posting, Mailing of Agenda, and Public Notice of the Meeting Agenda were executed in accordance with the Nevada Open Meeting Law. Chairman Malone noted that a quorum was present.

I. CONSENT AGENDA

Chairman Malone stated the Consent Agenda consisted of matters to be considered by the Airway Management Task Force that can be enacted by one motion. Any item may be discussed separately per Task Force member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Minutes Airway Management Task Force Meeting March 2, 2011

Chairman Malone asked for a motion to approve the minutes of the March 2, 2011 Airway Management Task Force meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion on Prehospital Nasotracheal Intubation

Dr. Malone started off the discussion by stating that there is very little data supporting prehospital nasotracheal intubation (NTI) as a useful skill and added that there are (3) factors that he feels strongly are good reasons for removing NTI from the protocols: additional costs, infrequency of use, and the damage that can be done to a patient. He asked the Task Force for their thoughts on retaining prehospital NTI.

Aaron Harvey stated that Henderson Fire has an in-house QI group made up of field medics who agreed it is used so infrequently and felt comfortable with it going away depending on what happens down the road with any type of medication assisted intubation. They felt that NTI is still an alternate airway to use if you are unable to get adequate relaxation.

Dr. Malone expressed the fact that in the prehospital environment there has always been a push towards "don't take a skill away from us" and stated that is certainly not the intention of this Task Force. It is not so much as taking away a skill as having a substantial reason to keep it by looking at the risk benefits and trying to do what is best for the community. In the context of removing NTI, there is talk about the introduction of Rapid Sequence Intubation (RSI) and he felt that would certainly be a logical argument to go back and discuss with your agencies.

Chief Tuke stated that since the last meeting he met with Dr. Bledsoe and Chief Vivier and identified 4 or 5 issues in the airway protocols that need to be addressed. He added that if NTI is going to be removed with the possibility of moving towards RSI, a better idea would be to not rush, take the time and continue with the research and then present it as a whole plan. He suggested only reporting the 4 or 5 issues to the MAB that have been identified as a problem in the airway protocols.

Chad Henry agreed stating that they want to do what is right for the patient and they know that NTI has a high propensity for damage to the airway so he would recommend that this Task Force identify and propose a plan to replace NTI by looking at an updated cricothyroidotomy procedure as well as facilitated intubation through RSI.

Dr. Malone proposed that by the next Airway Management Task Force meeting every agency come forward with their last years data on NTI, including how many were attempted, performed, successful, and what if any complications were encountered. With this information he will be able to provide the MAB with some pretty tangible information to further support the desire to strike NTI from the protocols and move forward with RSI.

A motion was made to have each agency collect 2010 data on Nasotracheal Intubation and report back to the Airway Management Task Force. The motion was seconded and passed unanimously.

B. Discussion on Rapid Sequence Intubation (RSI)

Dr. Malone asked Chief Tuke to update the members of the Task Force on the meeting he had with Chief Vivier and Dr. Bledsoe regarding RSI.

Chief Tuke stated that they didn't come to a final decision but just discussed the practicality of RSI. He felt that if you can manage a BLS airway you can manage somebody that you paralyze especially if you use a short acting paralytic. As far as just using certain medics or a certain subset of medics to do RSI is impractical, it needs to roll out as a system where everybody carries it. He expressed that fact that when RSI gets rolled out we approach it carefully and with strict guidelines and protocols. He felt that strict training needs to be done where various skills and experience can be obtained during the training process.

Dr. Malone informed the Task Force that during the preliminary discussion of RSI in the prehospital arena it was mentioned just having battalion chiefs or EMS supervisors have paralytics and sedatives on board to

facilitate but agreed with Chief Tuke on the impracticality of that suggestion. He proposed that the same group of individuals continue to research RSI and at the next Medical Advisory Board (MAB) meeting introduce the idea of RSI and let the Board know what their findings are thus far.

Mr. Harvey stated that after looking at their airway stats, RSI will help but felt it wasn't a magic bullet. He suggested that a significant amount of the training needs to go towards the actual intubation and technique.

Dr. Malone agreed and stated that it amazes him the number of patients that are brought in the Emergency Department (ED) not intubated in the field but yet it is the first thing that happens to them when they hit the ED door which makes him wonder where the problem lies. He felt the other area which everybody in the room does a phenomenal job of stressing is there is no magic bullet and no matter what is done in this Task Force or MAB, there is going to be a bad outcome and one thing that we always have to bear in mind and teach, aside from excellence, is understanding that bad outcomes happen and that's the purpose for the QI meetings so we can all learn from them.

Chief Tuke suggested going to the MAB with a total airway plan that includes RSI.

A motion was made to evaluate an airway plan and present it to the MAB. The motion was seconded and passed unanimously.

C. Update on Needle Cricothyroidotomy Protocol

Mr. Chetelat stated that the needle cricothyroidotomy is an ineffective tool and suggested looking at alternatives. Chief Tuke agreed and stated he has looked at the Newtrach and Pertrach and feels that is the way to go but is still working on researching other cricothyroidotomy devices.

Mr. Chetelat questioned whether there is any data on the number of needle cricothyroidotomies that have been attempted. Mr. Harvey stated that Henderson Fire keeps extensive airway data dating back to 2004 and there have been none.

Dr. Malone questioned if they were considering getting rid of needle cricothyroidotomy across the board or just in adults because he felt that the pediatric arena deserves special attention. Mr. Harvey stated he would want to maintain needle cricothyroidotomy for pediatrics but remove the physician order because in an emergency procedure you don't have time to get them on the phone.

Dr. Malone agreed and advised the Task Force that he will look up data on different prehospital cricothyroidotomy devices and have a presentation available at the next meeting. He also suggested tabling the removal of the physician order from the pediatric needle cricothyroidotomy until next meeting.

Dr. Malone made a motion to research other cricothyroidotomy devices and report back to the next Airway Management Task Force meeting. The motion was seconded and passed unanimously.

D. Discussion to Create a Separate Pediatric Advanced Airway Algorithm or Protocol

Tabled

Dr. Malone suggested that the Airway Management Task Force meet every other month instead of monthly to allow more time for research.

A motion for the Airway Management Task Force to meet every other month was made, seconded, and carried unanimously. The next meeting will be held on June 6, 2011.

III. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business, Chairman Malone called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 9:41 a.m.