Draft Minutes of Meeting – Subject to Change Upon Approval by the Drug/Device/Protocol Committee at their next regularly scheduled meeting

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

September 5, 2018 – 9:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR, Chairman
Jason Driggars (Alt.), AMR
Mark Calabrese (Alt.), CCFD
Shane Splinter, HFD
Jason Driggars, MWA
Spencer Lewis (Alt.), MFR
K. Alexander Malone, MD, NLVFD
Chelsea Monge (Alt.), Community Ambulance
David Slattery, MD, LVFR
Jim Kindel, BCFD
Derek Cox, LVFR
Jarrod Johnson, DO, MFR
Steve Johnson, MWA
Frank Simone, NLVFD
Matt Horbal, MD, MCFD
Derek Cox, LVFR

MEMBERS ABSENT

Daniel Rollins, MD, BCFD
Jeff Davidson, MD, MWA
Kim Moore, HFD
Shane Race, Mercy Air
David Slattery, MD, LVFR
Tressa Naik, MD
Jill Jensen, RN, JTM
Shawn Tobler, MFR

SNHD STAFF PRESENT

Scott Wagner, EMSTS, Field Representative
Rae Pettie, Recording Secretary
Gerald Julian, EMSTS, Field Representative

PUBLIC ATTENDANCE

Matt Horbal, MD
Fernando Juarez
Tiffany Pinkerton
Ashli Walker
Daniel Shinn
Karen Dalmaso-Hughey
Joshua Anziano
Julie Woolbright
Alyssa Ball
Rebecca Carmody
Chris Racine
Michelle Zahn
Scott Scherr, MD
Melanie Robison
Shane Splinter
Derek Minyard
Brandie Green

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, September 5, 2018. Chairman Mike Barnum called the meeting to order at 9:04 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Barnum noted that a quorum was present.

I. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public on items listed on the Agenda. All comments are limited to five (5) minutes. Chairman Barnum asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Barnum stated the Consent Agenda consisted of matters to be considered by the Drug/Device/Protocol Committee that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: August 1, 2018

Vice-Chairman Tuke asked for a motion to approve the August 1, 2018 minutes of the Drug/Device/Protocol Committee meeting. *A motion was made by Mr. Johnson, seconded by Mr. Simone and carried unanimously to approve the minutes as written.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Draft Burns Protocol - Tabled

B. Review/Discuss Draft Prehospital Death Determination Protocol

Scott Wagner presented the revised draft Prehospital Death Determination protocol to the committee for their review. He noted that a suggestion was made at the previous meeting to add two leads to the non-traumatic arrests asystole section. Mr. Wagner asked for feedback from the committee to ensure there would be no confusion. Mr. Simone stated that historically they have always done the two lead and the monophasic because of the possibility of activity in the one lead. He would be fine with confirming asystole in two leads.

A motion was made by Mr. Simone to adopt the revisions to the Draft Prehospital Death Determination Protocol as written. The motion was seconded by Mr. Johnson and carried unanimously.

C. Review/Discuss Afrin and Neosynephrine on SNHD Ambulance Inventory

Mr. Simone noted that both Afrin and Neosynephrine are required on the inventory. He asked whether they could remove the Neosynephrine since both medications are vasoconstrictors. They use Neosynephrine during nasal intubation and Afrin for the nose bleed. Dr. Barnum asked if they wanted to get rid of one, or should they provide an option? Dr. Johnson suggested they leave both as an option because of all the shortages in the pharmaceutical industry.

A motion was made by Mr. Simone to add Afrin to the Nasal Intubation protocol and allow for the option to utilize it or Neosynephrine. The motion was seconded by Mr. Splinter and carried unanimously.

D. Review/Discuss the Use of Droperidol in Chest Pain Patients

Mr. Wagner stated that no direct changes were offered to add a pearl or warning about Droperidol and its side effects in certain cardiac patients, including chest pain.

After much discussion, Dr. Barnum suggested they table the discussion and bring back a draft protocol to the next meeting.

E. Review/Discuss the Termination of Resuscitation Protocol

Mr. Calabrese stated the capnography <10 puts a lot of the cardiac arrests that are terminated outside of the protocol. Dr. Barnum asked if anybody had a suggestion to change the protocol to address the issue. Mr. Simone replied that it may be problematic because the <10 is from the AHA (American Heart Association). If the capnography is <10, check the quality of your CPR. But that got morphed into determination of resuscitation. Dr. Barnum agreed that we shouldn't be using something as a marker of adequate CPR for determination of resuscitation. Otherwise, anybody who is getting inadequate CPR would never be called. Mr. Calabrese stated if the capnography is <10 something has gone wrong with the call; the tube's bad, the chest compressions are poor and/or you're hyperventilating the patient. Dr. Johnson replied he would argue that if you had capnography <10

you didn't do adequate CPR so maybe it shouldn't be stopped. Rather than giving the patient the chance to receive adequate CPR and see if they come back, you should have a certain time with CPR with capnography <10 and if no response, you can then say adequate CPR hasn't brought them back.

Dr. Barnum if it would be better to state "adequate waveform." You want to see that you've got waveform, but you're not really worried about the number. You're worried about once you know you have waveform that will tell you that the airway is okay, you're moving air in and out, but if you're still not getting a rhythm back, that's going to be the determining factor. Mr. Cox gave a retrospective review of all the cardiac arrests. Not one person survived that had an End Tidal CO_2 <10. To be able to get a good, effective capnography an advanced airway is going to have to be placed. The protocol doesn't state they have to have an advanced airway, just effective ventilations. The crews rely on getting a physician order no matter what the capnography is. Dr. Barnum reiterated that the problem is we pulled an AHA number that is trying to assess for the adequacy of CPR and we're trying to use it as a viability number. Mr. Calabrese agreed to do further research and report back at the next meeting.

Dr. Barnum suggested they look at B.2 "Provide effective ventilation with 100% oxygenation for two (2) minutes." He stated they don't ever want to require people to have 100% CO_2 SAT, which is how he reads it, before they can terminate resuscitation. He asked if it was meant to read "100% O_2." He suggested they review the reason the protocol exists so they're not taking viable people Code 3 through the rest of the community and putting the crews and community at risk for a very poor reason. The point of this is not to be so overly concerned that we transport non-viable patients. We want to try to find a way to sort out the viable ones without missing any.

Dr. Johnson suggested revising it to read, "The patient remains in persistent asystole and agonal rhythm after 20 minutes of effective CPR." He noted that the cardiac arrest and airway protocols mention capnography; nothing about waveform or the number on them. He added that that is the place to address the fact that they should be using the capnography to make sure that during that 20 minutes you were doing compressions. If after 20 minutes somebody has adequate compressions and a CO_2 of 16, that person is still dead if they're in asystole and we haven't done anything. That person doesn't need to be transported. If during that 20 minutes you have capnography readings of 8, then something was wrong beforehand and they probably still deserve that 20 minutes to work unless they're in rigor mortis. There is no absolute number that somebody has to be at to be dead. After much discussion the Committee agreed to continue discussion of both issues at the next regularly scheduled meeting.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Chairman Barnum asked if there were any informational items to be discussed. Mr. Calabrese introduced Dr. Scott Scherr as one of Clark County Fire Department's new co-medical directors. The other medical director is Dr. Michael Holtz.

V. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chairman Barnum asked if anyone wished to address the Committee pertaining to items listed on the Agenda.

Michelle Zahn stated there is no alternative to Diazepam in the Pediatric Ventilatory Management Protocol. The Committee agreed to look at the protocol at the next regularly scheduled meeting.

ADJOURNMENT

There being no further business to come before the Committee, Chairman Barnum called for a motion to adjourn. *A motion was made by Member Cox, seconded by Member Simone and carried unanimously to adjourn at 9:49 am.*