MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

February 4, 2009 --11:00 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Chairman
Allen Marino, MD, MWA
John Higley, EMT-P, MFR
Eric Dievendorf, EMT-P, AMR
David Slattery, MD, LVFR
Eric Anderson, MD, Southern Hills Hospital
Bruce Evans, EMT-P, NLVFD
Scott Vivier, EMT-P, HFD
Jo Ellen Hannom, RN, CCFD
Sandy Young, RN, LVFR
Mary Levy, RN, UMC

MEMBERS ABSENT

Chief Kevin Nicholson, BCFD
Ron Tucker, EMT-P, MWA
E.P. Homansky, MD, AMR
Tien C. Wang, MD, Sunrise Hospital

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
Trish Beckwith, EMSTS Field Representative
Lan Lam, Recording Secretary
Mary Ellen Britt, R.N., Regional Trauma Coord.
Rae Pettie, EMSTS Project Coordinator
Judy Tabat, Administrative Assistant

PUBLIC ATTENDANCE

Larry Johnson, EMT-P, MWA/AMR
Rebecca Dennon, UMC
Jill Jensen, EMT-P, LVMS
Eric Perry, EMT-I, HFD
Beau McDougall, EMT-I, BCFD
Tom Lauro, CSN
Jarrod Johnson, DO, MFR
Barbara Larsen, CSN
Chief Mike Myers, LVFR
Tricia Klein, NCTI
Kady Dabash, EMT-P, MWA
Jeff Johnston, RN, Sunrise Hospital
Derek Cox, EMT-P, LVFR
Aaron Leong, EMT-I, MWA
Mike Sharrar, NCTI
Jennifer Navarro, NCTI
Dorita Sondereker, RN, MA
Amelia Hoban, Sunrise Hospital
Bob Byrd, EMT-P, AMR
Casey Carpenter, EMT-I, NLVFD
Joseph Meyer, EMT-I, NLVFD
Matthew Duggan, CSN
Eric Prieto, CSN
Wade Sears, MD, FES
Brian Rogers, EMT-P, HFD
Gonzalo Ausqui, CSN
Frank Marchionne, NCTI
Don Hales, EMT-P, MWA
Amy Bochenek, CHHMC
Michael Consul, EMT-I, AMR
Kenneth Ramirez, EMT-I, MWA
David Juarez, NCTI
Julie Siemers, RN, MA
Willa Dixon, SHMC

I. CONSENT AGENDA

The Drug/Device/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, February 4, 2009. Chairman Richard Henderson, M.D., called the meeting to order at

11:00 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson noted that a quorum was present.

Minutes Drug/Device/Protocol Committee Meeting August 6, 2008

Dr. Henderson asked for a motion to approve the minutes of the August 6, 2008 Drug/Device/Protocol Committee meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Revisions to Operational and Procedure Protocols (Bundle A)

Dr. Marino noted that he divided the Protocol/Formulary Review into three sections:

1. Module A (Operations & Procedures)
2. Module B (Treatment Protocols) to be reviewed in April or May:

General Patient Care	Burns
Abdominal Pain, Back Pain, Flank Pain (non-traumatic)	Ob/Gyn Emergencies
Allergy/Anaphylaxis	Overdose/Poisoning
Altered Mental Status	Pulmonary Edema/CHF (adult)
Behavioral Emergencies	Respiratory Distress w/Bronchospasm
	Trauma

3. Module C (Treatment Protocols) to be reviewed in June, July or August:

Acute Coronary Syndrome (suspected)	Cardiac Dysrhythmia – SVT
Advanced Airway Management	Cardiac Dysrhythmia – Torsades
Cardiac Arrest	Cardiac Dysrhythmia– VFib or Pulseless VTach
Cardiac Dysrhythmia – Asystole	Hyperkalemia (adult)
Cardiac Dysrhythmia – Bradycardia	Shock (non-traumatic)
Cardiac Dysrhythmia – Mono VTach	

Dr. Marino mentioned that if anyone would like to add a new drug, device or protocol/procedure, they need to take the necessary measures to place it on the MAB's consent agenda for consideration.

Dr. Slattery stated that as he read through the protocols, he found some to be very verbose. He suggested that everyone participate in taking a protocol and condensing it to one page wherever possible.

The following protocols were reviewed from Module A (Operations):

Chronic Public Inebriate – John Higley brought to the Committee's attention that NRS458.270 states "an intoxicated person found in any public place or under the influence of alcohol in such condition that he's unable to exercise care for his health or safety or the health or safety of other persons must be placed under civil protected custody by a peace officer." It goes on to state that the peace officer is to transport the patient to the appropriate facilities. Mr. Higley questioned whether this was addressed when writing this protocol. Mr. Chetelat stated that he would contact the Las Vegas Metro Police Department to get their opinion and report back to the Committee at the next meeting.

Do Not Resuscitate (DNR) – Dr. Marino stated that the patients are confused about DNR. They have living wills set up and believe they will be honored when EMS is called. He asked whether the Southern Nevada Health District has done anything to educate those who prepare the wills. Mary Ellen Britt reported that there were a few presentations done 3-4 years ago but not since then. Mr. Chetelat pointed out that there is a difference between a living will and a DNR card issued by SNHD. Living wills are formed more generically but the DNR card issued by SNHD must be signed by a Nevada physician stating that the patient is terminally ill.

Jo Ellen Hannom related that she has received calls from various crews on scene with a patient who has a valid DNR card, but another person with power of attorney advises the medics to resuscitate the patient. Legal opinion has been sought and concluded that the power of attorney does not invalidate a DNR. Ms. Hannom asked if a note could be added to the card for clarification. Dr. Slattery volunteered to condense the DNR protocol and Mr. Chetelat agreed to work on verbiage to address the power of attorney issue.

Inter-facility Transfer of Patients by Ambulance – Dr. Marino stated that there was an issue with 6.I. which states, "In certain situations, it may be necessary that a patient receive, just prior to transport, a medication which ambulance attendants are not authorized to use. If this medication will exert its effect during the transport, then appropriate personnel from the initiating facility must accompany the patient." Dr. Marino stated that he received clarification from Dr. Joe Heck that this refers to medication which exerts a cardiovascular effect. Dr. Henderson questioned the Committee on which medication a patient would be given that would make a medic believe they couldn't transport. He expressed a desire to exclude this verbiage from the protocol. Dr. Jarrod Johnson volunteered to condense the protocol to one page.

Pediatric Patient Destination – This item was tabled.

Sandy Young asked the Committee for clarification on the transport of a pediatric burn patient. Trish Beckwith stated that these patients would be taken to UMC's pediatric emergency department. Ms. Young questioned whether this should be included in the protocol. Mr. Chetelat suggested that they review the language in the burn protocol prior to making any changes to this protocol.

Prehospital Death Determination – Dr. Slattery suggested placing No. 4, "If possible, do not leave a body unattended. Once a responsible person (i.e. coroner's investigator, police, security, or family member) is present at the scene you may be excused." and No. 5, "Never transport/move a body without permission from the coroner's office, except for assessment or its protection." in an alert box. John Higley noted that "you" should be changed to "EMS Provider."

Chief Scott Vivier related a case from Austin, TX regarding the declaration of a dead person during triage. The determination was later over-ruled because the medical director of the hospital pointed out that a protocol was not in place which allowed a medic to declare a person dead in a triage situation. Chief Vivier noted that they have the ability to declare a person dead in a Mass Casualty Incident (MCI) due to lack of respirations after opening up the airway but triage should be addressed in this protocol or create a separate protocol to address triage/MCI situations. Chief Bruce Evans suggested an additional protocol to address these situations as well as to clarify the number of ambulances needed for certain MCIs based on the triage criteria; especially with litigations regarding why some patients received resources while others didn't when their injuries were similar. Dr. Slattery volunteered to condense the protocol to one page.

Quality Improvement Review – In an effort to increase MAB involvement, Dr. Marino suggested adding verbiage to No. 6 to state, "A quarterly aggregate summary of the incidents reviewed by the office of EMS & Trauma System will be prepared and reported at the Quality Improvement Directors' and MAB meetings."

Termination of Resuscitation – Dr. Marino questioned how often medics are getting turned down when contacting a physician regarding the termination of resuscitation. Ms. Young advised that it happens occasionally. Dr. Marino felt it would be helpful for this protocol to be disseminated to the medical directors at each emergency department. Chief Vivier questioned whether trauma calls should be directed to the closest facility or the trauma facility within the catchment area. Dr. Marino stated that he would direct the question to the Regional Trauma Advisory Board (RTAB) and report back at the next meeting.

John Higley noted that "you" should be changed to "EMS Provider."

Trauma Field Triage Criteria – Dr. Marino volunteered to condense the protocol and present it to the RTAB for approval.

The following protocols were reviewed from Module A (Procedures):

Combitube/Combitube SA – Ms.Young suggested that due to budget constraints, the protocol should be renamed "esophageal airway device" so it is not specific to the Combitube brand. There was a consensus that the protocol should not specify a specific brand. Troy Tuke recommended developing a short list of different airway devices for approval by the Committee. Chief Vivier pointed out that having a list of various airways would add confusion as the current protocol provides a step-by-step procedure on the operation of one specific airway. He suggested they remove the step-by-step process from the protocol and include it in their education. Chief Evans agreed and suggested adding verbiage that states the use of an esophageal airway is necessary after three failed intubation attempts. Ms. Young volunteered to draft a revised protocol for review at the next meeting.

Defibrillation – Dr. Slattery read No. 1 which states, "Defibrillation involves the delivery of non-synchronized direct electric current to the myocardium of a patient exhibiting ventricular fibrillation or ventricular tachycardia without palpable pulses/blood pressure. The objective of defibrillation is to depolarize the entire myocardium, which, it is hoped, will result in allowing a single reliable pacemaker site to assume pacemaker control at a rate capable of producing an adequate cardiac output." He suggested they remove the verbiage from the protocol and include it in their education.

Endotracheal Intubation – Ms. Young stated there is no protocol to address the use of the nasogastric (NG) tube. She recommended adding verbiage to this protocol.

Dr. Henderson proposed the removal of No. 1 which states, "Nasotracheal intubation is the technique of passing an endotracheal tube through the nose and pharynx into the trachea. This is done without using a laryngoscope to visualize the vocal cords (blind technique)."

Mr. Higley recommended revising No. 5 to replace "End-tidal CO_2 detectors" with "A CO_2 monitoring device."

Dr. Slattery volunteered to make the above revisions to the protocol, including the addition of the indications and contraindications, and to condense it to one page.

Needle Cricothyroidotomy – Chief Evans questioned the necessity of a protocol due to the fact needle cricothyroidotomies are rarely performed. Dr. Slattery stated that although it is a rarely used procedure, it is an important backup tool to have for paramedics that are a distance away from the hospital as it provides oxygen to the brain. He added that keeping the protocol would do little harm. Dr. Henderson felt that keeping the protocol would be costly with regard to training and maintenance of equipment. Ms. Young suggested they refer the issue to the QI Directors Committee to review outcomes so they can make an informed decision. Chief Vivier volunteered to draft a revised protocol for review at the next meeting pending the results from the QI Directors Committee.

Needle Thoracentesis – Chief Evans stated that he was approached by the tactical medics who questioned the gauge of the needles. Chief Vivier referred to a study published in a recent article from *Pre-Hospital Emergency Care* stating that 4.4cm needles fail in 50% of adults. They recommended 5cm or two inches in length.

Spinal Immobilization – No suggested changes

Synchronized Cardioversion – Dr. Slattery suggested they remove No. 1 which describes synchronized cardioversion and include it in the education.

Tracheostomy Tube Replacement – Ms. Young questioned whether the protocol was written for the ILS or ALS level. Ms. Beckwith clarified that it is technically an ALS protocol but if a family member was around to assist, a BLS or ILS provider could perform this protocol. Chief Evans felt the protocol is similar to the intubation protocol and should be performed by an ALS provider.

Transcutaneous Pacing – Dr. Henderson suggested they remove No. 1 which describes transcutaneous pacing from the protocol. Dr. Marino suggested adding the indications/contraindications. Mr. Tuke volunteered to draft a revised protocol for review at the next meeting.

Vagal Maneuvers – Dr. Henderson suggested they remove No. 1 which describes vagal maneuvers from the protocol. Dr. Marino suggested adding the indications/contraindications. Mr. Tuke volunteered to draft a revised protocol for review at the next meeting.

Vascular Access – Ms. Young suggested they divide the protocol into three parts: vascular access, extremity IO, and existing lines, along with the addition of indications/contraindications. Mr. Higley questioned why ILS providers are not allowed to perform intraosseous access in rural areas. Mr. Tuke felt the issue warranted further discussion because it would require additional training. Ms. Young suggested the protocol be optional for ILS providers with the blessing of their individual medical directors. Mr. Tuke responded he would be open to the idea of making it optional but will still need time to adjust for the change.

Dr. Slattery stated that PICC Line and Port-A-Cath should be two separate protocols.

Dr. Henderson suggested they remove No. 3.B. through 3.E. which describes the procedure and include this in their education. Ms. Young volunteered to draft a revised protocol for review at the next meeting.

Request to Receive Committee Agenda/Minutes by Electronic Mail

Dr. Henderson furnished the Committee members with forms to complete giving them the option to receive meeting notices by email or by US mail.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None

V. ADJOURNMENT

As there was no further business, Dr. Henderson called for a motion to adjourn. The motion was made, seconded and passed unanimously to adjourn at 12:17 p.m.