MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

September 5, 2012 – 09:00 A.M.

MEMBERS PRESENT

Jarrod Johnson, DO, Chairman, MFR
Eric Anderson, MD, MedicWest Ambulance
August Corrales, EMT-P, CSN
Gina Schuster, EMT-P, Community Ambulance
Derek Cox, EMT-P, LVF&R (Alt)
Richard Henderson, MD, Henderson Fire Department
Pat Foley, EMT-P, CCFD (Alt)
Tony Greenway, EMT-P, AMR (Alt)
Frank Simone, EMT-P, NLVFD (Alt)

MEMBERS ABSENT

David Slattery, MD, Las Vegas Fire & Rescue
Michele McKee, MD, UMC
Chief Troy Tuke, Clark County Fire Department
Scott Scherr, MD, Sunrise Hospital
K. Alexander Malone, MD, North Las Vegas Fire
Eric Dievendorf, EMT-P, AMR

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
John Hammond, EMS Field Representative
Judy Tabat, Recording Secretary
Mary Ellen Britt, Regional Trauma Coordinator
Kelly Morgan, MD, EMS Consultant

PUBLIC ATTENDANCE

Scott Morris, EMT-I, NLVFD
Jo Ellen Hannom, RN, CCFD
Larry Johnson, EMT-P, MWA/AMR
Jim McAllister, EMT-P, LVMS
Aaron Harvey, EMT-P, HFD
Steve Johnson, EMT-P, MWA
Rick Resnick, EMT-P, MFR
Sarah McAllister, EMT-P, LVMS
Jessy Rogers, EMT-P, HFD
Paul Stepaniuk, EMT-P, HFD

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in Classrooms # 1 and # 2 at American Medical Response – Las Vegas on Wednesday, September 5, 2012. Chairman Jarrod Johnson, D.O. called the meeting to order at 9:07 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Johnson 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. Chair Johnson 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 Johnson 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.

Minutes Drug/Device/Protocol Committee Meeting, August 1, 2012

Dr. Johnson asked for a motion to approve the minutes of the August 1, 2012 Drug/Device/Protocol Committee meeting. *Motion made by Member Henderson, seconded by Member Corrales and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of Selected Protocols

Medical	**Trauma**
Shock (Adult/Pediatric)	General Multisystem Trauma
Drowning (Adult/Pediatric)	Traumatic Brain Injury
Smoke Inhalation (Adult/Pediatric)	Extremity Trauma/Crush Syndrome
Overdose (Adult/Pediatric)	Amputation
Cardiac Arrest (Adult/Pediatric)	Assault/Abuse
OB/GYN Emergencies	Hanging
Tachycardia (Adult/Pediatric)	

Chair Johnson opened the meeting by stating that the Committee will first review the medical protocols which include Drowning (Adult/Pediatric) and Shock (Adult/Pediatric). He added that also included in their handouts, written by Dr. Johnson, a trauma fellow at UMC, is the recommended language for the trauma protocols that was brought to this Committee for consideration.

Dr. Morgan referred to the Drowning and Pediatric Drowning protocols and stated that she collaborated with Dr. Semsprott who is a 3rd year resident at UMC and an international expert on drowning. She added that with the emphasis on ventilation it was also noted that if the patient is breathing on their own, they recommended a non-rebreather (NRB) at 15-lpm, and if they are not, positive pressure ventilation with a Bag Valve Mask (BVM) was recommended and she will put those in as caveats. The Committee reviewed both the Drowning and Pediatric Drowning protocols and suggested the following changes:

- Add a box to include traditional CPR
- Add NRB at 15-lpm
- Move capnography up with 12 lead EKG as a paramedic skill

Dr. Johnson asked for a motion to approve the Drowning and Pediatric Drowning protocols with the recommended changes.

Motion made by Member Henderson, seconded by Alt. Member Simone and carried unanimously.

Dr. Morgan referred to the Shock Protocol and explained that it starts out with the General Adult Assessment (GAA), IV Access, monitor and then inserted a box that says "appropriate treatment protocols as indicated" as a jumping off point to go to another protocol if they have identified the reason for the shock.

Dr. Henderson suggested changing "Appropriate treatment protocols as indicated" to "Alternative appropriate treatment protocols as indicated" to give the box a better explanation.

Dr. Morgan explained that one of the big changes on the trauma branch point was to limit IV fluids in trauma patients. It was recommended that looking for the radial pulse in the patient would be the measurement whether or not you need to give fluids along with the concept of permissive hypotension in trauma.

There was some discussion regarding having IV Access as a separate box under the General Adult Assessment (GAA) box when in fact IV access is included in the GAA. It was decided to leave it as is because it is worth stating again on certain protocols

Mr. Greenway stated that in the GAA it states that oxygen treatment should be titrated to maintain a SPO2>94% but if somebody is exhibiting signs of shock regardless of what the pulse ox is, they should be given 100% oxygen (O_2) via a NRB. Dr. Morgan agreed and stated she will add that above IV Access as a basic skill.

Mr. Cox voiced concern regarding oxygen being addressed throughout the different protocols or just addressing it once in the GAA. Dr. Morgan stated that she addressed it in a specific protocol only if there is something different that would be recommended. After considerable discussion it was decided to leave it as is and use the educational pearls for more information. Mr. Cox agreed but added that he would like to revisit this in the future.

Mr. Simone suggested for consistency and education changing the NS Bolus under Non-trauma to 500ml.

Mr. Corrales stated that the Dopamine titrate to SBP > 100 mmHg should be > 90.

Dr. Johnson asked for a motion to approve the Shock Protocol with the recommended changes:

- Add "Alternative" to the "Appropriate treatment protocols as indicated" box
- Add oxygen / NRB at 15 lpm
- Change titrate to SBP > 90 mmHg
- Change NS Bolus 1000 ml to 500 ml in the Non-trauma box.
- Add capnography to the cardiac monitor box.

Motion made by Member Corrales, seconded by Alt. Member Simone and carried unanimously.

Dr. Morgan stated that the Pediatric Shock protocol isn't much different than the Shock protocol. She removed the cardiogenic component and added glucose as a cause of shock.

Dr. Johnson stated that "Alternative" will be added to the "appropriate treatment protocols as indicated" box as well as the oxygen and NRB under General Adult Assessment and suggested moving the blood glucose normal line up because it gets lost in the protocol.

Frank Simone questioned the systolic blood pressure (SBP) > 100 for pediatrics. Dr. Morgan stated that it will be different depending how old the child is and asked the Committee how they want to word it. Mr. Simone suggested age appropriate or size appropriate. Dr. Johnson agreed stating that it should be on the education page and use the term age appropriate in the box. Mr. Corrales felt that in the heat of the moment it would be better to use SBP > 70 + 2x the age up to 10 years. The Committee agreed.

Aaron Harvey suggested added capnography to both the Adult and Pediatric Shock Protocol. Dr. Morgan agreed stating she will change the Cardiac Monitor box to ready Cardiac Monitor/Capnography.

Dr. Johnson asked for a motion to approve the Pediatric Shock protocol with the following changes:

- Add oxygen / NRB at 15 lpm
- Alternative appropriate treatment
- Move the blood glucose normal line up
- Change SBP to 70 + 2x age up to 10 years old.
- Add capnography to the cardiac monitor box.

Motion made by Member Corrales, seconded by Alt. Member Greenway and carried unanimously.

Dr. Morgan asked the Committee to refer to the trauma protocols in the handouts and explained that these were recommendations made by one of the Trauma Fellows at UMC whom she had asked for help on what they would like to see in EMS that is evidence based. The idea was to look over their recommendations and make changes before she formats these into an algorithmic format.

Mr. Cox commented that it was interesting that he suggested using the Glasgow Coma Scale (GCS) as a benchmark for which way treatment is going to go.

The DDP Committee reviewed the trauma protocols and made the following suggestions:

- Opposed to the repeat doses based on transport time on the General Multisystem Trauma, it should be based on the pain management protocol. *(comment made by Dr. Henderson)*
- Does there need to be a separate protocol on each of the trauma scenarios. *(comment made by Dr. Johnson)*

- Recommended to remove the Assault and Abuse protocol *(comment made by Ms. Britt)*
- Maintain O_2 saturation should be 94% to be consistent with current protocols *(comment made by Mr. Simone)*
- Change penetrating chest wound with suspected tension pneumothorax to suspected tension pneumothorax. *(Comments made by Dr. Johnson, Mr. Corrales, Mr. Simone)*
- Change GCS ≤ 8 to GCS < 8 *(comment made by Ms. Britt)*
- Change name from multisystem to general trauma protocol *(comment made by Mr. Simone)*
- Change soaked kerlix to moisten trauma dressing *(comment made by Mr. Cox)*
- Change 3-side gauze to occlusive dressing *(comment made by Mr. Cox)*

Dr. Morgan stated that the whole concept of presenting these protocols was to review them and see if this Committee agrees with the major recommendations with using GCS as an indicator, the permissive hypotension based on radial pulse, using BVM if you can maintain adequate oxygen saturations and the reverse trendelenberg which is a change from anything we have done before.

Mr. Cox added that as an observation there are studies that show that healthcare providers feel a pulse when there is no pulse and vise a versa and felt that it will be interesting to see what kind of feedback we get about whether they have a palpable radial pulse. Dr. Morgan expressed that fact that she can put in a caveat under Palpable Radial Pulse with SBP < 80 with or without a pulse and make it a 2 tiered requirement.

B. Review of the Research on the Following Drugs

- Solu-Medrol
- Atrovent
- Ketamine

Tabled

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None

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. Chair Johnson asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chair Johnson adjourned the meeting at 10:15 a.m.