



**MINUTES**

**EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)**

**EMS/TRAUMA PERFORMANCE IMPROVEMENT COMMITTEE**

**March 18, 2009 – 1:30 P.M.**

**MEMBERS PRESENT**

Allen Marino, MD, Chairman	Sean Dort, MD, St. Rose Siena Hospital
Mary Ellen Britt, RN, Regional Trauma Coordinator	Kim Dokken, RN, St. Rose Siena Hospital
Melinda Hursh, RN, Sunrise Hospital	Jay Coates, DO, University Medical Center (Alt.)
Eric Dievendorf, EMT-P, MedicWest (Alt.)	Gregg Fusto, RN, University Medical Center
Michael Metzler, M.D., Sunrise Hospital	Brian Rogers, EMT-P, Henderson Fire Dept
Don Hales, EMT-P, MedicWest	Julie Siemers, RN, Mercy Air Service, Inc.

**MEMBERS ABSENT**

John Fildes, MD, University Medical Center	Larry Johnson, EMT-P, MedicWest
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**SNHD STAFF PRESENT**

Rory Chetelat, EMSTS Manager	Moana Hanawahine-Yamamoto, Recording Sec.
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**PUBLIC ATTENDANCE**

Troy Tuke, EMT-P, Clark County Fire Department	Jo Ellen Hannom, RN, Clark County Fire Department
Roni Mauro, EMT-P, MedicWest Ambulance	Teressa Conley, St. Rose Siena Hospital

**CALL TO ORDER – NOTICE OF POSTING**

The EMS/Trauma Performance Improvement Committee convened in Human Resources Training Room #2 of the Ravenholt Public Health Center on Wednesday, March 18, 2009. Chairman Allen Marino called the meeting to order at 1:32 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Marino noted that a quorum was present.

**I. CONSENT AGENDA**

Chairman Marino stated the Consent Agenda consisted of matters to be considered by the EMS/Trauma Performance Improvement Committee that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes/EMS/Trauma Performance Improvement Committee Meeting: 2/18/09

Chairman Marino asked for approval of the minutes of the February 18, 2009 meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

## II. REPORT/DISCUSSION/POSSIBLE ACTION

### A. Discussion of Performance Indicators for EMS/Trauma Assessment

The committee discussed the various indicators that were submitted for consideration. Dr. Marino clarified that the data would only include trauma field triage criteria (TFTC) patients.

#### EMS Response to Scene Times/EMS On Scene Times/EMS Transport Times (scene to hospital)

EMS system response-time intervals are easily quantifiable but it is important not to overemphasize response-times because it can lead to harmful consequences like emergency vehicle crashes.

The computer-aided dispatch (CAD) captures the data for EMS system response-time intervals; however, the CAD data is not sensitive enough to identify trauma patients and there are too many variations when selecting destination locations.

Brian Rogers advised that although Henderson Fire Department's patient care report (PCR) contains a checkbox for TFTC patients. The PCR is only available in paper form and would require Mr. Rogers to review each and every PCR manually to identify the TFTC patients. Mary Ellen Britt asked if the EMS agencies would be able to provide the response-time information if they were given a list of the TFTC patients from the trauma centers. Don Hales stated that the trauma centers would need to provide the incident numbers as well. Melinda Hursh explained that they would be willing to provide that information if it is completed on the PCR form. Based on the data provided at the Trauma Medical Audit Committee, approximately 40% of EMS documentation is incomplete or missing.

The standard measure for EMS response to scene time is 8 minutes and 59 seconds with a 90% compliance requirement.

The standard measure for EMS on scene time is less than 10 minutes for the first arriving unit and less than 20 minutes for extrication. The expectation is to be 90% compliant with these response-times but it is not required. Dr. Michael Metzler added that the on scene time should begin when the EMS crews are allowed access to the patient. Prolonged times due to safety issues must be taken into consideration.

The trauma centers felt it would be beneficial for the EMS agencies to report when they fall below the benchmarks for all three response-time intervals. This will allow additional research to be done to determine the reason for the fall outs.

Mr. Rogers noted that the EMS agencies will need to figure out how they will collect these response-times. Ms. Hursh advised that the EMS agencies could audit a percentage of their transports for compliance rather than reviewing all of the records. If the audit identifies a trend, then EMS would need to drill down on that information.

Ms. Hursh suggested that since there is a long list of indicators, it might be best to select a couple of indicators quarterly. If areas of improvement are identified and addressed, another indicator would be measured during the next quarter.

Dr. Marino reported the importance of gathering the response-time information and asked the EMS agencies to explore how the data will be collected and how frequently will it be reported.

#### EMS Transports Outside of Catchment Zones

This information is currently being reported from the TFTC monthly transport data to the Regional Trauma Advisory Board.

#### Patient Care Reports (complete, incomplete, missing)

This information is reported by the trauma centers to the Trauma Medical Audit Committee on a quarterly basis.

### Number/Type of Transfers to/from Trauma Centers

This information is reported by the trauma centers to the Trauma Medical Audit Committee on a quarterly basis.

### Aeromedical Safety

Dr. Metzler asked that all safety landing zone issues be reported back to the committee. Julie Siemers advised that she will be able to provide Mercy Air's data to the committee.

### Telemetry Success

Dr. Metzler advised that they have an issue with EMS not consistently giving enough notification regarding transports. It is important that EMS understands that this notification allows the trauma centers to prepare for the patient. The trauma centers will decide if there are telemetry issues that need to be reported to the committee.

### Secured Airway/GCS<8

Dr. Metzler felt that the medics should secure an airway if the transport time exceeds a specific time limit. Ms. Hursh noted that if the patient's GCS is less than 8, there should always be a secured airway. Gregg Fusto reminded the committee that if the medic is unable to adequately ventilate the patient, by protocol, the patient must be transported to the nearest emergency department.

Mr. Rogers explained that one can secure an airway, maintain an airway or be unable to maintain an airway. He clarified that maintaining an airway could include a bag valve mask or securing it with intubation. If the medic is able to adequately ventilate the patient, by protocol, they are able to continue the transport to the nearest trauma or pediatric center.

Dr. Marino believed it would be too difficult to decide what would be an acceptable time limit with regard to the transport time and requiring the medic to secure the airway. This critical judgment should be left up to the medic. Mr. Rogers mentioned that as a medic the golden rule is to get the patient from the scene to the hospital as quickly as possible. If a time limit is imposed, the medic will take the time to intubate the patient. When time is critical, is this something we want to encourage?

Julie Siemers added that the objective is to verify if the medics are making these critical judgments appropriately. The committee decided that the trauma centers would review all of the secured airway/GCS < 8 cases and report any adverse outcomes. The trauma centers will determine if it was an inadequate airway and submit the reason.

### CPR

Dr. Metzler wanted EMS to call the trauma centers every time they initiate CPR on a trauma patient; however, it was understood that the medic would be too busy with the patient and the driver would be driving code 3 with lights and sirens, making it difficult to call. Dr. Metzler explained that the trauma center makes certain decisions regarding patient care based on the amount of time CPR has been performed; therefore, it is important that the time given by the medics is as accurate as possible.

If a trauma patient requires CPR, EMS advised that the monitor is turned on. Once the monitor detects CPR has been started, the time and date will be marked on the strip.

Dr. Marino stated that MedicWest ambulance is currently holding mandatory meetings. He will make sure that the medics are aware that they need to pull all code summaries when CPR has been initiated on a trauma patient and that the strip needs to be handed to the trauma center upon arrival.

It was agreed that the EMS agencies would educate their crews about the importance of getting the time CPR was initiated and that the code summaries on trauma patients need to be given to the trauma centers upon arrival. This indicator was removed from the list.

GCS Calculation

The committee stated that GCS calculations from the field and within the trauma centers cannot be compared to one another; therefore, it would be difficult to measure the appropriateness of the GCS calculation. This indicator was removed from the list.

Hypothermia

Dr. Metzler would like a total count of trauma patients who are hypothermic.

DOA (within 15 minutes upon arrival)

This information is being reported by the trauma centers to the Trauma Medical Audit Committee on a quarterly basis.

Needle Thoracostomy

Dr. Marino mentioned that there are articles stating that the needles being used by EMS for thoracostomy may be too short. Therefore, every time EMS performs a needle thoracostomy on a trauma patient, it will be reported to the trauma centers on a monthly basis and the trauma centers will provide the outcomes as well as any issues to the committee. Dr. Marino indicated that the justification for the thoracostomy should be noted in the PCR.

Pre-hospital Sedations for Combativeness (versed)

Dr. Marino explained that Scott Vivier requested that the pre-hospital use of versed for combativeness in all trauma cases be reviewed. Therefore, every time EMS uses versed for combativeness on a trauma patient, it will be reported to the trauma centers on a monthly basis and the trauma centers will provide the outcomes as well as any issues to the committee.

Protocol Deviations

Kim Dokken reiterated that the mission of the committee is to ensure the coordination, integration, efficiency and effectiveness of the interface between EMS and the trauma system; therefore, if there is a performance improvement issue with EMS that relates to a system wide problem, then it needs to be addressed in this committee. It was decided that IV access as well as appropriate immobilization would be included in this category. The data will be reported as a total count per deviation. Ms. Dokken asked that a list of the possible deviations be created to standardize the reporting process.

Dr. Marino mentioned that he will take this list of indicators to the Medical Advisory Board for their endorsement and support in reporting this data.

B. Discussion of EMS Trauma Patient Case Definition

Tabled.

C. Discussion of Out of Area Trauma Transports

Tabled.

**III. INFORMATIONAL ITEMS/DISCUSSION ONLY**

None

**IV. PUBLIC COMMENT**

None

**V. ADJOURNMENT**

As there was no further business, Chairman Marino called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 2:30 p.m.