MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

February 5, 2020 – 10:00 A.M.

MEMBERS PRESENT

Mike Barnum, MD, AMR, Chairman
Karen Dalmaso-Hughey, AMR
Walter West, BCFD (Alt)
Chief Shawn Tobler, MFR
Chief Kim Moore, HFD
Ryan Fraser, AirMed Response (Alt)
Chief Jennifer Wyatt, CCFD
Shannon Ruiz, PharmD
Jim McAllister, LVMS
Samuel Scheller, GEMS
Steve Johnson, MWA
Derek Cox, LVFR
Chief Lisa Price, NLVFD (Alt)
Matthew Horbal, MD, MCFPD
Bryce Wilcox, CA

MEMBERS ABSENT

Alicia Farrow, Mercy Air
Devon Eisma, RN, OM

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Med. Director
Rae Pettie, Recording Secretary
Laura Palmer, EMSTS Supervisor
Candace Toyama, EMSTS Field Representative

PUBLIC ATTENDANCE

Michael Holtz, MD
Troy Tuke
Tricia Klein
Brett Olbur
August Corrales
Shane Splinter
Jarrod Johnson, DO
Tony Greenway
Jeff Davidson, MD
Rebecca Carmody
Dan Shinn
Maya Holmes
David Slattery, MD
Jessica LeDuc, DO
Breann Montesanto

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee (DDP) convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, February 5, 2020. Chairman Mike Barnum called the meeting to order at 10:10 a.m. and stated the Affidavit of Posting was posted 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 Mike Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one, Dr. Barnum 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 DDP 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: December 4, 2019

Chairman Barnum asked for a motion to approve the December 4, 2019 minutes of the DDP meeting. *A motion was made by Troy Tuke, seconded by Kim Moore, and carried unanimously to approve the minutes as written.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Nomination of Chair and Vice Chair

Dr. Jessica Leduc was nominated as the new Chair, and Dr. Michael Holtz was nominated as the new Vice Chair for the calendar year 2020.

A motion was made by Mr. Tuke, seconded by Chief Moore, and carried unanimously to approve Dr. Jessica Leduc as the new Chair, and Dr. Michael Holtz as the new Vice Chair.

B. Review/Discuss Hemostatic Agents/Bandages for Bleeding Control

Dr. Slattery stated that one of the gaps in the hemorrhage protocol is junctional bleeding control for wounds to the groin, axilla and neck. He suggested they consider following the TECC Guidelines, which recommend using a hemostatic agent and wound packing training for junctional bleeding control. He noted that what the EMS providers do in the first minutes for this subset of patients will make a difference in survival to a trauma center.

Dr. Slattery related that he spoke with tactical paramedic teams, both in the military and urban environment, who specified two combat hemostatic agents for the committee to consider. Although there are many hemostatic agents, combat gauze has probably gone through the most clinical trials and is a TECC approved agent. It is an impregnated gauze that requires no new muscle memory or having to learn a new skill. BMK Ventures Inc. sells it in different lengths: 4x4 gauze, which is excellent for the neck; and 4-foot rolls that can be used for axillary and femoral wounds. He stated the cost varies from $3 to $10, depending on the vendor. Dr. Slattery stated the second popular product is Celox which is not gauze, but a type of cardboard that is impregnated. Instead of having a hemostatic agent, it absorbs moisture out of the blood and creates a gel. The downside is that it's a little more difficult for surgeons to extract compared to the combat gauze, which may be problematic. He noted there aren't many clinical studies because the product is new. However, the combat gauze has been proven to be effective and reliable. Dr. Slattery expressed that the Education Committee should dictate the necessary training on how to pack a junctional wound and control the bleeding. Dr. Young was in agreement that they should move forward. He related that after the "Stop the Bleed" campaign was launched, training related to the packing of wounds is now being provided to members of the public.

Dr. Leduc noted that the combat gauze alone doesn't solve the entire problem. Direct pressure is still the #1 tactic for hemorrhage control. The impregnated gauze, as opposed to the older powders they used in the military, is less messy and less problematic on the receiving end. That would be the message that needs to be conveyed to the RTAB. She noted that junctional wounds are troubling because of their location. There are great devices currently being tested in the field. They're probably more expensive, but it may be something to consider in the future.

Dr. Slattery stated the language he would like added to the protocol was taken straight out of the TECC guidelines. The DDP proposed the following revisions to the "Hemorrhage Control Tourniquet" protocol:

1. Change the name of the protocol to "Hemorrhage Control."
2. Add a section titled "Junctional Hemorrhage" with language that reads, "Use direct pressure and an appropriate pressure dressing with deep wound packing (plain gauze or, if available, hemostatic gauze)."

Mr. Corrales suggested they include language to eliminate confusion that packing a wound does not exclude the necessity for a tourniquet. Chief Tobler suggested they also note that wound packing is contraindicated for abdominal wounds.

Chief Tobler asked whether they need to include the RTAB (Regional Trauma Advisory Board) in the decision-making process. He stated the issue was brought forward years ago with the "Stop the Bleed" campaign and the RTAB precluded them from moving forward. Dr. Young stated the RTAB's rationale at the time was that using compounds made it technically more difficult on the receiving end. He agreed that the RTAB should be involved. Dr. Slattery stated he doesn't anticipate any of the trauma surgeons opposing the new language. Dr. Barnum suggested they present the revised protocol to the RTAB to elicit their assistance on implementing the change rather than asking whether the change should happen. Mr. Splinter asked whether the RTAB can rescind the MAB's decision to move forward. Dr. Slattery stated it is the medical director's role to identify, inform, and empower the crews with the right tools to deliver appropriate care to the community. Junctional control training and allowance of hemostatic agents is recommended by national organizations, as evidenced in "Stop the Bleed." He feels that as leaders in the EMS system it is their decision to make. Dr. Slattery was in favor of taking the approved protocol to RTAB to ensure they are not deploying anything that's going to be problematic from their perspective. Ms. Palmer agreed to make the necessary revisions to the protocol and forward it to the RTAB to see if they would like to add additional information which can be included in the education component.

A motion was made by Dr. Holtz, seconded by Mr. Cox, and carried unanimously to approve revisions made to the Hemorrhage/Tourniquet protocol.

C. Review/Discuss Prehospital Death Determination (PDD) and Termination of Resuscitation (TOR) Protocols

Dr. Young reported there will be ongoing discussion at the QI Directors meeting associated with diligent monitoring and assessment of patients that are presumed to be deceased. North Las Vegas Police Department representatives shared their perspective on crime scene contamination, which was enlightening. There was some resistance related to concerns about crime scene contamination. The bottom line is that EMS can't be prevented from accessing patients to assess them. However, there needs to be a more cooperative collaboration on scene. Dr. Young stated the QI Directors will continue to report back on any additional developments or recommendations related to the PDD and TOR protocols.

Several agencies stated they have received feedback from the crews about placing a 12-lead on a patient with obvious rigor mortis. There is a gray area of placing a monitor on a patient that has clearly expired. Chief Wyatt added that the crews want more clarification, more concrete examples on the definition of "functional separation." The DDP agreed that it will be beneficial to provide additional education.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

Dr. Young reported the QI Directors Committee is continuing its review of the PDD and TOR protocols in peer review sessions. He noted that a couple of law enforcement officers attended the meeting which added a whole other dimension to the discussion of crime scene awareness. They look forward to working with them.

Mr. Cox asked if they could expand the pediatric dosing for the Cyanokit. The current dosing table stops at a 10-year old. They would like guidance on whether to give an 11-year old a weight-based dose. The DDP agreed to place the Cyanokit on the next MAB consent agenda.

Dr. Leduc referred the DDP to the H's and T's (reversible causes) on the Cardiac Arrest (Non-traumatic) protocol. She stated one of the training officers very astutely questioned why we would give Calcium Chloride to somebody who is hypokalemic, which is correct. She asked if they could separate hypokalemic from hyperkalemic for the purpose of clarification. Ms. Palmer stated it would be a simple housekeeping change.

Dr. Barnum stated there has been discussion about human trafficking at the ED/EMS meeting. He noted there may be a need for a protocol to assess vulnerable populations in the future.

Chief Wyatt noted the Termination of Resuscitation protocol states that a patient must remain in persistent asystole for 20 minutes of "paramedic" resuscitation. A paramedic was on scene at Kindred helping with a code for ten minutes. A doctor walked in and called for termination of resuscitation. They were hesitant to stop because they hadn't gone the full 20 minutes. They understand that a higher level of care was making the call, but the way the protocol is written was the cause of some confusion. Chief Wyatt stated the question was, "Who is in charge of that call and that code?" Dr. Slattery replied that a physician is obviously a higher authority from a medical perspective. However, he would argue that paramedics are the highest level of care for resuscitation in that environment. He stressed that if a paramedic thinks a decision is not appropriate, they always have access to medical control to take

over that decision. Chief Wyatt stated she just wanted confirmation that there wasn't a protocol deviation that needed to be documented. Mr. Cox stated the TOR protocol states that termination of resuscitation can only be discontinued by a telemetry physician. It doesn't say anything about a facility physician. Dr. Holtz noted that if there is no telemetry contact you can terminate resuscitation if a physician order is provided, so that would be acceptable. Dr. Barnum suggested they continue the discussion in the QI Directors Committee to address the agencies' concerns.

Dr. Slattery thanked Dr. Barnum for the fantastic job he has done during his tenure in juggling both the DDP and MAB committees as Chair.

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 included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Barnum asked if anyone wished to address the Board. Seeing no one he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, Chairman Barnum adjourned the meeting at 10:59 a.m.