MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE

April 6, 2022 – 10:00 A.M.

MEMBERS PRESENT

Michael Holtz, MD, CCFD, Chair
Chief Jennifer Wyatt, CCFD
Kelly Morgan, MD, NLVFD
Chief Shawn Tobler, MFR
Sam Scheller, GEMS
Shane Splinter, HFD (Alt)
Derek Cox, LVFR
Jessica Leduc, DO, HFD
Mike Barnum, MD, AMR
David Slattery, MD, LVFR (Alt)
Chief Stephen Neel, MVFD
Nigel Walton, BCFD
Chief Frank Simone, NLVFD

MEMBERS ABSENT

Nate Jenson, DO, MFR
Alicia Farrow, Mercy Air
Troy Biro, AirMed
Jim McAllister, LVMS
Devon Eisma, RN, OptimuMedicine
Karen Dalmaso-Hughey, AMR
John Osborn, CA

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Med. Director
Laura Palmer, EMSTS Supervisor
Scott Wagner, EMSTS Field Rep.

PUBLIC ATTENDANCE

Kat Fivelstad, MD
Jeff Davidson, MD, MWA
Bud Adams
Matthew Dryden
Fernando Juarez
Sandra Horning, MD
Lloyd Jensen, MD
Brett Olbur
Nathan Root
Scott Phillips

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol (DDP) Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, April 6, 2022. Chairman Michael Holtz called the meeting to order at 10:06 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Some Committee members joined the meeting via teleconference and the roll call was administered by Laura Palmer, EMSTS Supervisor, who noted that a quorum was present.

I. FIRST PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Holtz asked if anyone wished to address the Board pertaining to items listed on the Agenda. He noted

that after discussion at the previous meeting the pediatric dosing for Versed was updated in the protocol, but not in the formulary box. Ms. Palmer stated she will make the change as appropriate.

II. CONSENT AGENDA

Dr. Holtz stated the Consent Agenda consists 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.

1. Approve Minutes for the Drug/Device/Protocol Committee Meeting: March 2, 2022

   A motion was made by Dr. Barnum, seconded by Dr. Morgan, and carried unanimously to approve the Consent Agenda as written.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Termination of Resuscitation Protocol and Prehospital Death Protocol

Mr. Hammond referred the Committee to the draft Termination of Resuscitation (TOR) protocol revisions that were made based on input at the last meeting, and from physician partners. He noted there were questions related to what defines a "rural" and a "wilderness" area. "Urban" is defined as having a population greater than 50,000. It includes all our rural fire stations, including Mesquite and Boulder City. Everything that is not urban is considered rural. "Wilderness" is an area that has not been developed in any manner. It's not a farm; it's not a city; it's not a township; it doesn't have roads. The Committee recognized housekeeping adjustments that need to be made to the TOR protocol. Dr. Holtz asked whether there is a mechanism to review the cases where resuscitation was terminated without medical control. Mr. Hammond replied that we would need to request those charts from the agencies or ESO. He agreed they should review charts prior to making decisions related to the emergency care protocols.

Mr. Hammond referred the Committee to the draft Prehospital Death Determination (PDD) protocol and stated there was considerable discussion at the last meeting. The recommendation from the QI Directors Committee (QI) was to remove "E. Functional separation from the body of the heart, brain, or lungs" in its entirety because it's superfluous and not supported nationally. There is no way to define all the traumatic instances that would cause someone to perish. Instead, it was agreed they would add language stating if there's any question as to the viability of the patient, the EMS provider would contact medical control for further direction. If it's a traumatic arrest, they would call a trauma center; if it's a medical arrest, they would call a regular receiving facility.

The Committee discussed different scenarios related to patient access such as entrapment or entanglement, and how to address this subset of patients in the protocol. Mr. Hammond suggested they keep it simple, clear, and easy to follow, while providing adequate guidance through medical control should strange issues arise, because they can't account for everything that's going to occur that causes the death of a human being. Chief Simone stated the education piece should cover how the protocol is defined.

A motion was made by Mr. Walton to make the following revisions to the Termination of Resuscitation protocol and the Prehospital Death Determination protocol:

Termination of Resuscitation protocol:

1. *Revise 3.A.3. to read, "Administration of appropriate ACLS medications, if available.*
2. *Add 3.A.4. to read, "Confirm no organized rhythm or a PEA <40 or 'No Shock Advised' on AED.*
3. *Revise NOTES at bottom to read, "In rural or wilderness situations, EMS providers must make every effort to contact medical control, but resuscitation may be terminated in the field without medical control when any of the following have occurred: A. There has been no return of pulse despite greater than 20 minutes of CPR and effective ventilation (consider extending in the case of hypothermia or drowning). B. Transport to an emergency department will take greater than 40 minutes (consider extending in the case of hypothermia or drowning. C. The EMS providers are exhausted and its physically impossible to continue the resuscitation."*

Prehospital Death Determination protocol:

1. *Revise 1.E. to read, "For other injuries suspected to be incompatible with life, medical control must be contacted to proceed with medical direction." (Add radio icon to the left)*

2. *Delete 2. in its entirety.*
3. *Add A box that reads, "If there are any extenuating circumstances regarding access to patient, contact medical control."*

The motion was seconded by Dr. Morgan and carried unanimously by the Committee.

B. Discussion of Pediatric Cardiac Arrest Non-Traumatic Protocol

Dr. Fivelstad noted that further revisions were made to the draft protocol presented at the last meeting after concerns were brought up that it wasn't in alignment with PALS. The first was to move the Important Information box from the center to the top of the protocol, that reads:

- Transport with ROSC or scene time of 20 minutes active resuscitation.
- Pit Crew approach with assigned roles important for meet timing goals.
- 9% decrease in survival and 6% decrease in neurological status for every 1 minute epinephrine administration was delayed.

In addition, changing the previous verbiage under shockable rhythms to read, "Subsequent shocks ≥4J/Kg to max of 10J/Kg or adult dose" and "AMIODARONE 5 Mg/Kg IV/IO. May repeat to a total of 3 doses. Address Hs and Ts"

In addition, under Pearls, revise the verbiage to read "Adult paddles/pads may be used on children weighing greater than 10Kg" and add:

- Pre-plan drug dosing based on weight estimations while en route and verify with a height-based tape on encounter with the patient.
- Proper BVM Selection < 5Kg Infant bag, 5-30Kg Pediatric bag, >30 Kg Adult bag.

A motion was made by Dr. Barnum to accept the above revisions to the Pediatric Cardiac Arrest Non-Traumatic protocol. The motion was seconded by Chief Wyatt and carried unanimously by the Committee.

C. Discussion of CPAP Protocol and BiPap Pilot Program - Tabled

D. Discussion of Etomidate in Pediatric Intubation - Tabled

E. Discussion of Adult and Pediatric Ventilation Management Protocols - Tabled

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

None.

V. SECOND PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Holtz asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 11:05 a.m.