MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

February 2, 2011--10:00 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Chairman
Eric Anderson, MD, MedicWest
Jarrod Johnson, DO, MFR
Derek Cox, EMT-P, LVFR (Alt.)
Chief Scott Vivier, HFD
Chief Troy Tuke, CCFD
Gina Schuster, EMT-P, Community Amb
E.P. Homansky, MD, AMR
David Slattery, MD, LVFR
Christian Young, MD, BCFD (Alt.)
Steve Johnson, EMT-P, MWA (Alt.)
Eric Dievendorf, EMT-P, AMR
Rick Resnick, EMT-P, MFR

MEMBERS ABSENT

Chief Bruce Evans, NLVFD
Mary Levy, RN, UMC
Chief Tom Miramontes, LVFR
Mark Calabrese, EMT-P, MWA
Kevin Nicholson, BCFD

SNHD STAFF PRESENT

Rory Chetelat, EMS Manager
Trish Beckwith, EMS Field Representative
Mary Ellen Britt, Regional Trauma Coordinator
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Nancy Cassell, EMT-P, CSN
Tracey Metcalf, RN, TriState CareFlight
Gerry Julian, Mercy Air
Carrie Cochran, EMT-P, LVMS
Will Mills, NCTI
Jo Ellen Hannom, RN, CCFD

CALL TO ORDER – NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, February 2, 2011. Chairman Richard Henderson, M.D., called the meeting to order at 10:14 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson noted that a quorum was present.

Dr. Slattery announced that Dr. Jarrod Johnson from Mesquite Fire & Rescue will be the new vice chair of the Drug/Device/Protocol Committee.

I. CONSENT AGENDA

Chairman Henderson 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, November 3, 2010

Dr. Henderson asked for a motion to approve the minutes of the November 3, 2010 Drug/Device/Protocol Committee meeting. A motion to accept the minutes was made, seconded and passed unanimously.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Addition of Pediatric Supraglottic Airway Device as an Item to the Official Air Ambulance, Ground Ambulance & Firefighting Agency Inventory

Trish Beckwith asked for a recommendation regarding sizes of King Airway devices to replace the Combitube and Combitube-SA. She added that the King 3, 4 & 5 meets the range of the former Combitube sizes but if toddlers are to be considered then a range of 2 & 2.5 would be necessary.

Dr. Slattery stated that he asked that this be sent to the Airway Committee. Dr. Henderson agreed.

B. Protocol Review

The following Treatment Protocols (Bundle A) were reviewed:

General Patient Care (GPC) – Dr. Henderson addressed Section D2: Breathing, Item 2a "12-15 lpm NRB to all patients (including COPD) experiencing cardiovascular, respiratory, or neurological compromise" stating that current literature and recommendations from the American Heart Association (AHA) are moving away from this and felt that this statement should be removed. Derek Cox suggested hearing from the National Faculty in PALS, ACLS and BLS on what those recommended changes are before changing the protocols. Chief Vivier stated that they have released those changes and the information is out there to review. Rick Resnick agreed stating that the AHA is encouraging instructors to utilize the roll out tools that are available to get familiar with the changes and start implementing those into current course curriculums. Ms. Britt advised the Committee that Philis Beilfuss who is a member of the AHA National Faculty for ACLS has offered to review the protocols and make recommendations for changes based on the new AHA standards. The Committee agreed to have Ms. Beilfuss review the protocols that involve ACLS. Chief Vivier questioned Dr. Henderson on what language would replace Item 2a. Dr. Henderson stated he would strike it and just go to Item 2b and say "to all patients with no history of prescribed home oxygen". Dr. Slattery suggested a statement that directs them to administer a supply of oxygen to maintain oxygen saturations above 95%. After a brief discussion it was decided Dr. Henderson will come up with the replacement language and bring it back for review.

Dr. Slattery referenced item 3 of the same section that states "Consider pulse oximetry, if available". He suggested that be expanded to say "If pulse oximetry is available, titrate oxygen delivery to maintain normal saturations" and then define what that is to cover all patients. Dr. Henderson stated he will send that out for everybody to comment.

Trish Beckwith reported that language was inadvertently left off in this version of the protocols that stated when you were transporting to a hospital a notification of transport should be made concerning all patients. This language was under Section G: Communications and labeled item 4. The Committee agreed to add it back.

Abdominal Pain, Back Pain, Flank Pain (Non-Traumatic) – Chief Vivier stated that this is probably a global change but questioned whether it was an oversight that morphine could not be given intramuscular (IM). Dr. Slattery stated that it must have been an oversight and added the possibility of using morphine intranasally (IN). Dr. Henderson stated that this Committee will address it when we get to the formulary for morphine.

Acute Cerebral Vascular Accident - No changes

Acute Coronary Syndrome (Suspected) – Mr. Cox questioned why EMT-Basics are not able give aspirin. Chief Vivier asked if aspirin is covered in the Basic EMT scope of training. Mr. Petrucci answered in the affirmative and stated that it is presented as a tool. Dr. Anderson stated that if it adds more work to the education of the BLS providers then he would not suggest adding it to BLS skill since

aspirin is effectively delivered to 100% of patients that need it. Dr. Henderson stated that moving it up to the BLS level would get it to the patient earlier. Mr. Petrucci added that in the new standard guidelines coming out, aspirin is in EMT education so he didn't think it was asking a lot to enhance that if they choose to put that into the scope of practice. Chief Tuke agreed stating it would help his volunteers in the rural areas. The Committee agreed to move Item 7 up to the BLS skill.

Advanced Airway Management – Dr. Slattery stated that any airway protocol will be reviewed by the Airway Committee.

Allergy Anaphylasix – No changes

Altered Mental Status – Dr. Henderson questioned Item 8. The protocol suggests giving 2mg of Narcan as the initial dose and he felt it should be a titrated dose to give the medic a choice. Chief Vivier asked if he was looking to add the one word so it reads "administer Narcan, titrate up to 2mg as the initial dose"? Dr. Henderson answered in the affirmative. Dr. Slattery expressed that fact that not knowing whether the medic is bagging the patient or what the patient saturation level or vital signs are .4mg is not going to turn them around and they will be waiting too long. Dr. Henderson asked if he would be good with saying "administer Narcan 1 to 2 mg". Dr. Slattery agreed.

Behavioral Emergencies – No changes

Burns – Dr. Slattery stated that "suspected inhalation injuries" needs to be added to the alert box as an added item. Dr. Henderson questioned why the 2 figures of an adult and child are still in this protocol since it is considered education and recommended that they should be removed. Chief Vivier asked about cyanide treatment and if that is a standalone protocol. Dr. Slattery stated that is in the Smoke Inhalation Protocol and asked if that protocol was part of this Bundle. Ms. Beckwith stated that the Health District is still waiting on the educational component of the Smoke Inhalation protocol. Dr. Slattery stated that the Smoke Inhalation protocol has been approved by the MAB and it should be part of this manual.

Adult CCR Cardiac Arrest – Chief Vivier stated that the only controversy to this protocol is the witnessed vs. unwitnessed arrest. The AHA does state that there is no science for or against that in their recent literature and recommend that the local advisory committee or their experts should decide. Dr. Slattery stated that the Resuscitation Outcomes Consortium (ROC) presented a large trial that looked at this very topic and the results were absolutely no difference in patient outcomes. In the presentation that will be published this year the investigators basically said that there is little support for the recommendation to do 2 minutes of CPR first before you analyze in an unwitnessed arrest. He added that just chest compression only CPR is something that we have to look at because we expected that to be in the new guidelines.

Cardiac Dysrhythmia: Asystole – Chief Vivier stated that one change is that Atropine will be removed because that is no longer in the AHA guidelines. Dr. Henderson questioned why Item 3 is listed in this protocol since it is pure education. Chief Vivier stated that it does direct to specific treatments. Ms. Beckwith agreed and stated that it does give the provider a reference guide and a jumping point where they can link to other protocols. She felt that sometimes a little more is better and suggested to leave it in. Dr. Slattery stated that the only one that doesn't really have a support in protocol is the sodium bicarb for the acidosis and recommended removing the link. The Committee agreed.

The following Protocols will be referred to Philis Beilfuss
Cardiac Dysrhythmia: Bradycardia
Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia
Cardiac Dysrhythmia: Pulseless Electrical Activity
Cardiac Dysrhythmia: Supraventricular Tachycardia (Narrow Complex)
Cardiac Dysrhythmia: Torsades De Pointes
Cardiac Dysrhythmia: Pulseless Ventricular Tachycardia

Hyperkalemia – No change

Obstetrical / Gynecological Emergencies - Dr. Slattery asked that the Health District update the capabilities of each of the hospitals with the OB/Gyn table that is listed in the protocol.

Overdose / Poisoning – Chief Vivier asked if there was research out there indicating the use of calcium in a beta block overdose as an emerging treatment that is more efficacious than glucagon or even dopamine. Dr. Slattery stated there were some studies but couldn't quote them. Dr. Henderson asked that Chief Vivier research this and bring it back for discussion.

Pulmonary Edema / CHF (Adult) – No change

Respiratory Distress with Bronchospasm – Dr. Henderson questioned Dr. Slattery on the use of atrovent in treating asthma/COPD stating that according to literature repeat doses of atrovent does help that patient and felt it should be a part of this protocol. He expressed concern with the procedure to bring a new drug on board when that drug is the standard of care in every other setting and proven in other EMS systems. Dr. Slattery stated the practice for evaluating a new drug or device must include evidence that the proposal is already supported in the literature before it is considered and that there is a measurable outcome. The Committee will then be given the opportunity to review the evidence and determine the cost of the proposed change before a decision is made. Dr. Henderson agreed with process and noted that he wanted to bring this back quickly before the July rollouts.

Shock (Non-Traumatic) – No change

Trauma - Dr. Henderson stated that current literature is saying if bleeding has not been controlled you do not aggressively administer IV fluids even if there's hypoprofusion. Dr. Slattery stated that there was a study published last month from the National Trauma Data Registry data in a retrospective fashion that looked at outcomes whether or not a patient received IV fluids for blunt trauma and it was concluded that their outcomes were slightly worse if they received IV fluids prior to coming to a trauma center. He added that the study was not strong and since they didn't control for injury severity he felt there was not enough evidence. Ms. Beckwith stated there is a significant discussion going on in education as well to allow for permissive hypotension in keeping a patient's blood pressure at around 100 or less which is being taught in PHTLS & ITLS. Dr. Slattery stated that there is an educational component to that and it's for penetrating trauma. He was concerned about this being extrapolated to all blunt trauma patients. Dr. Henderson suggested that Dr. Slattery go to Dr. Fildes to come up with the right definition and bring it back to the Committee.

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 10:58 a.m.