MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DRUG/DEVICE/PROTOCOL COMMITTEE

March 6, 2013 – 09:00 A.M.

MEMBERS PRESENT

Richard Henderson, MD, Acting Chairman, HFD
Eric Anderson, MD, MedicWest Ambulance
August Corrales, EMT-P, CSN
Pat Foley, EMT-P, CCFD (Alt)
Dorita Sondereker, Mercy Air
David Slattery, MD, Las Vegas Fire & Rescue
Tony Greenway, EMT-P, AMR (Alt)
Gina Schuster, EMT-P, Community Ambulance
Frank Simone, EMT-P, NLVFD (Alt)

MEMBERS ABSENT

Jarrod Johnson, DO, Chairman, MFR
Eric Dievendorf, EMT-P, AMR
K. Alexander Malone, MD, North Las Vegas Fire
Chief Troy Tuke, Clark County Fire Department
Derek Cox, EMT-P, LVF&R
Scott Scherr, MD, Sunrise Hospital
Rebecca Dennon, EMT-P, JTM

SNHD STAFF PRESENT

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

PUBLIC ATTENDANCE

Christian Young, MD, Boulder City Fire Dept
Scott Morris, EMT-I, NLVFD
Steve Johnson, EMT-P, MedicWest Ambulance
Richard Main, EMT-P, AMR
Dayna Blake, RN, TSCF
Collin Sears, Las Vegas Fire & Rescue
Paul Houghton, Las Vegas Fire & Rescue
Chris Gentry, LVAPEC
Kristen Fuentebella, LVAPEC
Nicholas Weaver, CSN
Eileen Davies, LifeGuard Int'l
Jim McAllister, EMT-P, LVMS
Steve Patraw, Boundtree
Tricia Klein, EMT-P, AMR
Victor Montecerin, EMT-P, MWA
JoEllen Hannom, RN, CCFD
Martin Tull, MWA
Richard Martindale, LVAPEC
Dale Kepler, CSN

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in Conference Room 2/2A at The Southern Nevada Health District on Wednesday, March 6, 2013. Acting Chairman Richard Henderson, M.D. called the meeting to order at 09:12 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson 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. Acting Chairman Henderson 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

Acting 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, February 6, 2013

Dr. Henderson asked for a motion to approve the consent agenda which included the minutes of the February 6, 2013 Drug/Device/Protocol Committee meeting. *Motion made by Member Corrales, seconded by Member Anderson and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of SVN as a Route of Administration for Narcan

Dr. Morgan stated there was some question at the last meeting regarding SVN as a route of administration for Narcan and it was decided to bring the discussion back as a separate agenda item along with research literature.

Frank Simone referred to the handouts and stated that the overall conclusion in all (4) articles say it is safe and effective and added that it lessens the abruptness of withdraw syndrome in narcotic dependent patients because of the slow onset of the route. Dr. Henderson agreed and stated that after reading the articles he came away convinced that it works but questioned if it is needed and asked if there is a strong sentiment to have this option.

Mr. Corrales felt that from a prehospital point of view it's good to have another route of administration for the medics.

Dr. Slattery stated that most of the evidence suggests that it is helpful and felt that anything that is done without using a needle is good and suggested that they do a randomize trial study to measure the outcomes.

Dr. Henderson asked for a motion to do a randomized study of Intranasal (IN) versus nebulized Narcan for that narcotic dependent patient that is an overdose with a respiratory rate < 6. *Motion made by Member Slattery, seconded by Member Corrales and carried unanimously.*

B. Discussion of Changes to Versed Dosage in Related Protocols

- Advanced Airway Management
- Altered Mental Status
- Behavioral Emergencies
- Cardiac Dysrhythmia: Bradycardia
- Endotracheal Intubation
- Obstetrical / Gynecological Emergencies
- Transcutaneous Pacing

Dr. Morgan advised that at the last meeting there was discussion regarding changing the dosing of Versed to *0.1mg/kg with no limit dose repeated ½ dose q5* in the Behavioral Protocol and it was suggested that this Committee consider a single dosing regimen across all seven (7) protocols that are impacted by any Versed changes and review what other EMS systems are using.

Mr. Simone referred to the Midazolam Dosing handout and stated he took 20 EMS agencies and outlined what they utilize for adult seizure, pediatric seizure and behavioral and reviewed his findings. In addition he also evaluated a variety of different articles, and studies and the consistencies in everything he found was that the ½ life of Midazolam will actually prolong in your renal patients and liver patients especially in the elderly over the age of 60. He added that overall it seems like they are on line when it pertains to the adult seizure regarding dosing but felt that the behavioral may need further adjustment.

Dr. Slattery questioned how many different dosing regimens they have for all the protocols where Versed is indicated. Dr. Morgan stated that it is the same dosing regimen.

Dr. Slattery suggested that it would be helpful to put at least in parenthesis when they talk about the ½ dose what that means which is 0.05mg/kg.

Dr. Henderson asked for a motion to make the dosing consistent across all the protocols using 0.1mg/kg (IN,IM, IV) may repeat every five minutes at ½ (0.05mg/kg) the original dose *Motion made by Member Simone, seconded by Member Anderson and carried unanimously.*

Mr. Hammond questioned when this will be rolled out and operational. Dr. Slattery felt this is an important patient safety issue and if the Medical Advisory Board (MAB) agrees they should retrain on this specifically as soon as possible.

C. Discussion of 2014 Protocols and Advised Changes Based on SNDH Focus Group: 01/22/2013

- General Assessment
- Abdominal Pain
- Allergic Reaction
- Altered Mental Status
- Burns
- Chest Pain
- Behavioral Emergencies

Dr. Morgan stated that the first (4) of these protocols were reviewed at the last meeting so they can start with the Burns protocol. She added that all these protocols have gone through this Committee previously, MAB and through the SNHD Focus Group for a second look. She advised that the next SNHD Focus Group will be on March 14th at 3:00pm and everyone is welcome.

Burns

- Changed max fluid to 60ml/kg in pediatrics

Dr. Henderson asked for a motion to approve the stated change. *Motion made by Member Corrales, seconded by Member Slattery and unanimously approved.*

Chest Pain

- Change SpO2 to ≥ 94%
- Change wheezing to constricted airways
- Clarify QI metric →12 Lead EKG w/in 5 minutes of patient contact

Dr. Henderson suggested using the term bronchospasm instead of constricted airway. The Committee agreed.

Dr. Slattery questioned the need for this protocol. Dr. Morgan stated this protocol was meant to be a jumping off point to help people remember there are other causes of chest pain other than suspected Acute Coronary Syndrome (ACS).

Dr. Slattery felt that they are not doing anything differently in this protocol then what they should be doing with all chest pain patients. He added that if he suspected aortic dissection and that pathway node in this protocol said take to a facility that has cardiovascular (CV) surgery capabilities then that would be an important step in that algorithm that would make a difference in the management of that patient.

Dr. Henderson asked Dr. Slattery if he was advocating a destination. Dr. Slattery stated that he was pointing it out for discussion.

Dr. Henderson stated that under the Pain Management box you could add a box that stated "Deliver to a Hospital with cardiovascular surgery capabilities."

Dr. Slattery made a motion that if they are going to keep the Suspected Aortic Dissection node in the protocol they should add a CV surgery capability hospital destination as the end point of this pathway.

Dr. Morgan questioned that if this creates a destination protocol that states these hospitals have CV surgery capability would it be getting too specific to say they should be able to be stabilized at any outside hospital and then transferred to a CV surgery capable facility since that has been an issue before.

Mr. Chetelat expressed concern regarding another destination policy. He advised that this should be addressed by the EMS Destination Criteria Committee because hospitals will start giving push back about why they are not included. He added that it is the mission of EMS is to get the patient to the next higher level of care and felt that they need to be careful about making it a true hard destination policy.

Dr. Anderson felt that suspected aortic dissection would be difficult to diagnosis in the field. Dr. Slattery agreed but felt that when a patient presents classically they should be preferentially brought to a CV surgery capable hospital.

Dr. Anderson stated that he would just get rid of the protocol. He felt that it is educational and if the medic doesn't feel it's cardiac then they don't have to give an aspirin.

Dr. Young stated that the spirit of this protocol was that not all chest pain is ACS and their job is to put guidance on those criteria. He felt they are completely blowing across the mission here when we are starting to talk about new receiving facilities when it's an old discussion for a different day.

Dr. Henderson stated that the consensus is that we don't want to go there but we have a motion on the floor and asked for a vote. Dr. Slattery withdrew his motion and suggested that they re-look at the chest pain.

The Committee agreed to table the Chest Pain protocol.

Behavioral Emergencies - Tabled

Mr. Chetelat advised the Committee that they need a vote to approve the first (4) protocols listed in that group that were not voted on last month.

Dr. Henderson asked for a motion to approve the General Assessment, Abdominal Pain, Allergic Reaction and Altered Mental Status protocols with the suggested changes that were discussed at the last DDP Meeting held on February 5, 2013. A motion was made by Member Simone, seconded by Member Corrales and unanimously approved.

D. Discussion of Status of Alternative Medications in Future Protocols

- Hydomorphone (Dilaudid)
- Fentanyl (Sublimaze)
- Diazepam (Valium)
- Ketamine (Ketalar)
- Droperidol (Inapsine)
- Propofol (Diprivan)

Dr. Morgan stated that there had been previous discussions regarding adding Ketamine and Droperidol on a more permanent basis expanding their usage specifically in the behavioral emergency protocol for excited delirium.

Dr. Henderson added that he would like to see Fentanyl made permanent.

Dr. Morgan agreed and added that initially Morphine and Fentanyl were both tier one medications with the thought that you would have both available to you and when this drug shortage disappears you could carry both to have an alternative for the borderline hypotensive patients. She added that she can pull some of the literature on Ketamine and Droperidol if this Committee would like to move this forward and there is a lot of research on Fentanyl since it is already in use out in the field. Dr. Henderson agreed and stated he would like to pursue that further.

Dr. Slattery added that he wanted to make sure that we add the 4mg/kg IM dose for Ketamine to the formulary.

E. Discussion of Adding Solu-Medrol to the Formulary for 2014

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. Acting Chairman Henderson 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, Acting Chairman Henderson adjourned the meeting at 10:02 a.m.