Draft Minutes of Meeting – Subject to Change Upon Approval by the Drug/Device/Protocol Committee At Their Next Regularly Scheduled Meeting

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

DRUG/DEVICE/PROTOCOL COMMITTEE

May 07, 2014 – 09:00 A.M.

MEMBERS PRESENT

Jarrod Johnson, DO, Chairman, MFR
David Slattery, M.D., LVF&R
Troy Tuke, EMT-P, Clark County Fire Department
Frank Simone, EMT-P, NLVFD
Clem Strumillo, EMT-P, Community Amb.
Brandon Hunter, EMT-P, MWA
Chuck Gebhart, Boulder City Fire Dept.
Bryan Bledsoe, DO, MWA
Chief Scott Vivier, Henderson Fire Dept
Derek Cox, EMT-P, LVF&R
August Corrales, EMT-P
Tony Greenway, EMT-P, AMR
Mike Barnum, MD, AMR

MEMBERS ABSENT

Rebecca Dennon, EMT-P, JTM
Dorita Sondereker, Mercy Air
K. Alexander Malone, MD, NLVFD
Tressa Naik, M.D., Henderson Fire Dept.
Rick Resnick, EMT-P, MFR

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Gerry Julian, EMS Field Representative
Judy Tabat, Recording Secretary
John Hammond, EMSTS Supervisor
Rae Pettie, EMS Program/Project Coordinator

PUBLIC ATTENDANCE

Dale Carrison, DO, CCFD
Tricia Klein, EMT-P, LVAPEC
Sarah McCrea, EMT-P, LVF&R
Chief Robert Horton, LVF&R
William Scott, CSN
Dan Deines, CSN
Jim McAllister, EMT-P, LVMS
Steve Krebs, MD, UMC
Eric Anderson, MD, MWA
Bryce Krason, AMR
Kenneth Fields, CSN
Morgan Helm, CSN

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Drug/Device/Protocol Committee convened in Conference Room 2 at The Southern Nevada Health District on Wednesday, May 07, 2014. Chairman Jarrod Johnson, D.O. called the meeting to order at 09:21 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Johnson 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 Johnson 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

Chairman Johnson 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, April 02, 2014

Chairman Johnson asked for a motion to approve the consent agenda which included the minutes of the April 02, 2014 Drug/Device/Protocol Committee meeting. *Motion made by Member Corrales, seconded by Member Simone and carried unanimously.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

Dr. Johnson started off the meeting by welcoming Dr. Mike Barnum as a new member of the Drug/Device/Protocol (DDP) Committee.

A. Review of Spinal Immobilization Protocol

Dr. Johnson stated that the Spinal Immobilization is the final protocol to work through and finalize. Dr. Young referred to the handout and added that the recommended changes made at the last meeting are noted in the summary of comments on the right side of the page.

There was considerable discussion regarding changing the language in Item b. from "Focal neurologic deficit" listed under Indication(s) to "NO neurologic findings or neurologic complaints" It was felt that someone with a headache or low back pain might be considered a neurologic complaint and wouldn't necessarily need to be immobilized. Dr. Slattery felt that was an educational issue and added that the language that was chosen was from the National Association of EMS Physicians (NAEMSP) position statement on that topic. Dr. Young stated that if you decide to use NO neurologic findings or neurologic complaints" you could add an educational component to say that a headache wouldn't be considered or keep it as "Focal neurologic deficit" and add an educational component to say if a patient has horrible pins and needles that may be someone who would benefit. Dr. Johnson felt that sensory findings can be focal neurologic deficits which can be educated on and they can still move towards the main goal of trying to eliminate backboards.

Dr. Slattery felt that a decision needs to be made by this Committee whether or not numbness constitutes a neurological deficit and needs to be immobilized, whether that decision is from an educational caveat or they change the protocol to reflect any neurological complaints excluding headache.

Dr. Carrison stated that they need to consider how to make that clear and then how to roll it out as an educational component so that our providers know what we want them to look for before making any decision.

Mr. Corrales stated that he would like to draft an education pearl for this protocol listing out what items would be sufficient for cervical stabilization and what items may not and have that back for the next DDP to consider.

Dr. Slattery asked Dr. Bledsoe if he would adjust his motion to include that numbness, tingling, and paresthesia are considered neurologic deficits. Dr. Bledsoe answered in the negative.

Frank Simone referenced the National Library of Medicine definitions of what they list as a focal neurological problem:

A focal neurologic problem can affect any of these functions: Movement changes including paralysis, weakness, loss of muscle control, increased muscle tone, loss of muscle tone, or movements a person cannot control (involuntary movements, such as tremor)

Sensation changes include paresthesia (abnormal sensations), numbness, or decreases in sensation

Dr. Slattery stated that with that definition he would support this.

Dr. Barnum added that he has been predominately in EMS education and would feel very comfortable leaving it at "focal neurologic deficit" and then going forward and trying to educate providers. He felt creating a pearl to that affect is a good idea and as a medical director leaving it up to the discretion of the paramedics to make that decision.

Member Bledsoe made a motion that the protocol as represented under indications letter "b" Focal neurologic deficit as consistent with Nexus criteria remains in the protocol. Seconded by Member Carrison and carried unanimously.

The second point of discussion was on removing the 3rd item in Key Procedural Considerations: "Backboards are only indicated for extrication and patient movement. Patients are not to be transported on backboards (unless movement of the backboard would delay immediate transport of patients with life threatening injuries) and replace it with: Full spinal immobilization should be used judiciously for extrication and patient movement. Appropriate patients to be immobilized with full spinal stabilization include those with:

- Blunt trauma and altered level of consciousness (GCS < 14)
- Spinal pain or tenderness
- Neurologic complaint (e.g., numbness or motor weakness)
- Anatomic deformity of the spine
- High-energy mechanism of injury and any of the following:
  - Drug or alcohol intoxication
  - Inability to communicate
  - Distracting injury

Dr. Bledsoe felt that this section defeats the whole purpose of the document.

Dr. Johnson believes that the main area of concern was for those patients who have known spinal fractures impinging on the spinal cord and the patient who has a high risk mechanism.

Dr. Bledsoe stated that they are going back to the presumption that spinal immobilization is a reasonable and affective practice. The standard of care in this community is not to put the patient on a backboard. The evidence that it is harmful outweighs the evidence it is beneficial.

It was stated that under this suggested criteria the provider is going to err in favor with almost immobilizing everybody.

Dr. Carrison asked Dr. Young to review the outcome of the survey that he sent out.

Dr. Young stated that he sent out a survey to every emergency room provider in the city and received 96 responses. The survey asked:

- If someone comes in on a backboard do you take them off right away, assuming they have pain and you are going to get some imaging studies?
- Do you take them off the backboard to do the x-rays or do you leave them on the backboard and do the x-rays and wait for the results or do you just leave them on the backboard.

The follow-up question was:

- If you now identify a fracture on that x-ray you just ordered, do you leave them on the backboard?
- Do you take them off the backboard and put them on a soft bed in a supine position?
- Do you take them off a backboard and put them on a soft bed in a position of comfort?

Unilaterally they all got off the backboard even if a fracture has been identified. There was a little bit of disparity in terms of keeping the patient in a supine position versus a position of comfort and some deferred to the decision of the neurosurgeon. He added that the hospitals need to do a better job of getting these patients off the backboards and felt from a Health District standpoint that they need to do a better job of reaching out to emergency providers with regard to this issue because tissue ischemia has been documented in minutes. He identified the other operational issue that needs to be addressed is how do our providers move a patient that has been extricated on a backboard off of the backboard on to a soft mattress. When they do it in a trauma center you have 6 people log rolling the patient, when you do it in the field on a 24 inch gurney while maintaining c-spine immobilization the patient is probably going to end up with a fracture.

Troy Tuke stated that if our providers put a patient on a board in the field, that patient will stay on the board until they get to the emergency department (ED). You can't compare the hospital treatment to prehospital treatment and felt they need to leave it in the paramedic's discretion on scene when they need the board. Dr. Bledsoe agreed.

Dr. Slattery stated that is not what is being proposed. Dr. Bledsoe stated that the original document stated "unless movement off the backboard would delay immediate transport of patients with life threatening injuries".

Dr. Slattery felt that they all agree that the vast majority of patients do not need to be on a backboard. Where there is disagreement both here and nationally was for the group for patients that have lost integrity of their spine and those patients with a spinal cord injury, those patients are high risk and there is no evidence that backboards do not work in that population. The momentum changes in the back of an ambulance just by normal driving to both the providers and the patients. He felt it would be a great benefit to define who doesn't need a board and then look at the data and base their decision on the data to further refine the definition.

Chief Vivier stated that the providers understand when they need to provide stabilization to the cervical spine with a type of splint but felt that a backboard is a horrible splint and doesn't provide any protection to the spine. He added that he would feel better padding, binding, or use a vacuum splint for spinal immobilization.

Member Bledsoe made a motion to go back to the original verbiage as stated "Backboards are only indicated for extrication and patient movement. Patients are not to be transported on backboards (unless movement off the backboard would delay immediate transport of patients with life threatening injuries). Seconded by Member Greenway and a vote was taken. The motion was approved by: Member Bledsoe, Member Barnum, Member Vivier, Member Simone, Member Corrales. The motion was opposed by: Member Johnson, Member Strumillo, Member Slattery, Member Tuke and Boulder City Fire. The motion did not carry.

Dr. Johnson felt that this may pass if they had a slight amendment to it and opened it up for another motion.

Dr. Carrison stated that his objection is that the statement should include known spinal injuries. Dr. Johnson agreed. Chief Vivier stated that he would second that as long as they are clear that spinal immobilization does not mean only a backboard. He added that for his agency they will use an alternative device to spinal immobilize.

Dr. Bledsoe modified his motion to say "Backboards are only indicated for extrication and patient movement. Patients are not to be transport on backboards (unless movement off the backboard would delay immediate transport of patients with life-threatening injuries or known spinal injuries).

Mr. Corrales suggested using the verbiage "acute" spinal injury as opposed to "known". Dr. Bledsoe agreed.

Dr. Slattery stated that by the first vote, they clearly don't have consensus, and added that this is a very important change to the system in regard to who needs to be immobilized. He suggested that they figure out what everyones concerns are and see if they could find common language that they can all have consensus on before moving forward.

Dr. Carrison stated that there is a motion on the floor, it's been seconded and it's up to this body by voting to determine if we have consensus or not.

Dr. Johnson asked that Dr. Bledsoe restate the motion and then call for a vote. Mr. Cox questioned who the voting members are. There are members and then there are alternates. There is a list of members on the minutes from last meeting and if those members are not present then it is their alternates.

Member Bledsoe made the motion to return the verbiage with the following modifications. The verbiage is: Backboards are only indicated for extrication and patient movement. Patients are not to be transport on backboards (unless movement off the backboard would delay immediate transport of patients with life-threatening injuries or acute spinal injuries). Seconded by Member Carrison and a vote was taken. The motion was approved by: Member Tuke, Member Simone, Member Strumillo, Member Bledsoe, Member Corrales, Member Greenway, Member Hunter, Member Vivier, and Member Johnson. The motion was opposed by: Member Slattery and Member Cox. The motion passed by a simple majority.

Dr. Johnson stated that the motion passed and added that they need to make sure they have good educational pearls as far as what is spinal immobilization versus spinal stabilization.

Mr. Greenway questioned Item e under Indications(s) "No Painful, distracting injury". His understanding is that if you have a painful distracting injury you have to immobilize.

Dr. Bledsoe added that there are 3 more comments that are highlighted on the right to discuss. "Patient found in motor vehicles should be asked to exit the motor vehicle on their own, if so they should be assisted to a soft stretcher and secured for transport. Patients unable to exit the vehicle on their own accord should be removed by the appropriate method and the patient should be removed by the most appropriate extrication method to minimize movement of the cervical spine". And then the other change that Dr. Young had made "should be removed from the backboard as soon as possible after arrival to the receiving facility". Dr. Bledsoe felt that statement is a hospital issue and should be addressed by the emergency department.

Dr. Young stated that for discussion purposes, that paragraph came up in discussion at the last meeting to replace what is in the orange highlight text. The last sentence was put in for the issue as stated if the backboard is used for extrication, the patient should be immediately removed to a soft mattress. Indicating there is a transfer from board to mattress somewhere in the field where you may not have resources to do that safely and operational how do you do that without dropping a patient. The idea was if that was the case you can leave them on the board. In the yellow highlighted area we are telling medics that they should be moving patients off backboards. We are going to need to clarify how to do that. So maybe we should say "Immediately move to a soft mattress, if possible." Dr. Johnson agreed.

Dr. Johnson stated he would like to agree on these changes that we are talking about such as "any" so let's take them one by one.

Member Bledsoe made a motion to change "E" No painful, distracting injury to "Any painful distracting injury". Seconded by Member Greenway and carried unanimously.

Member Bledsoe made a motion to accept the statement: "Patients found in motor vehicles should be asked if they are able to exit the motor vehicle on their own. If so, they should be assisted to a soft stretcher and secured for transport. Patients unable to exit the vehicle on their own accord should be removed by the appropriate extrication method". Seconded by Member Greenway and carried unanimously.

Dr. Young suggested adding that verbiage "if possible" after that statement. Dr. Bledsoe felt that was educational. Dr. Johnson felt that "if possible" is an important point.

Member Bledsoe made a motion to add "if possible" to that statement. Seconded by Member Strumillo and passed. Member Cox opposed the motion.

Mr. Hammond advised the Committee that he will have a clean version of the protocol to include all of the changes ready to present to the Medical Advisory Board.

B. Review of Draft Emergency Medical Care Protocol Manual

The Committee did a preliminary review of the protocol manual making recommendations for modifications. Mr. Hammond stated he would apply the modifications to the manual and have the final draft completed and sent out within the next 2 weeks to allow everyone the opportunity to review and submit any recommended changes prior to the next DDP meeting. He added that the final page on the appendix is going to be a guide on what the facilities have what resources with a disclaimer saying at the time of publication this is the most recent data we have.

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. Chairman Johnson 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, Chairman Johnson called for a motion to adjourn; the motion was made, seconded and passed unanimously to adjourn the meeting at 11:09 a.m.