MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

DIVISION OF COMMUNITY HEALTH

EDUCATION COMMITTEE

November 2, 2016 – 9:00 A.M.

MEMBERS PRESENT

Frank Simone, Chairman, NLVFD
Jim Kindel, BCFD.
Brandie Green, CSN
Derek Cox, LVFR
August Corrales, JTM
Kim Moore, HFD
Melanie Ondik, RN, CA
Steve Johnson, MWA

MEMBERS ABSENT

Steven Carter, AMR
Carl Bottorf, RN, LG
Don Abshier, CCFD
Devon Eisma, RN, MA

SNHD STAFF PRESENT

Christian Young, MD, EMSTS Medical Director
Laura Palmer, EMSTS Supervisor
Michelle Stanton, Recording Secretary
John Hammond, EMSTS Manager
Gerald Julian, EMS Field Rep.

PUBLIC ATTENDANCE

Eric Anderson, MD, MW
Timothy (TJ) Smith, HFD
Karen Hughes, MFR
Mike Barnum, MD, AMR
Jarrod Johnson, DO, MFR
Jim McAllister, LVMS

CALL TO ORDER - NOTICE OF POSTING OF AGENDA

The Education Committee convened in Red Rock Conference Room at the Southern Nevada Health District on Wednesday, November 2, 2016. Chairman Frank Simone called the meeting to order at 9:08 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Simone 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 Simone 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 Simone stated the Consent Agenda consisted of matters to be considered by the Education 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: Education Committee Meeting, April 6, 2016

Chairman Simone asked for a motion to approve the minutes of the April 6, 2016 Education Committee meeting. *A motion was made by August Corrales, seconded by Kim Moore and carried unanimously to approve the minutes as written.*

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Defining Successful Ventilatory Management Throughout the Emergency Medical Care Protocols

John Hammond stated the different verbiage used throughout the protocol manual related to the "ability to ventilate" vs. the "ability to intubate" has raised concerns with EMS providers. The confusion arises when a provider is able to ventilate, yet unable to intubate. At times this results in transports to the closest facility with a patient who was adequately ventilated, when another facility would have been more appropriate. Frank Simone asked if there is a need to better define "adequate ventilation"; a BVM and OPA also includes ventilation. Mr. Hammond replied in the affirmative, stating they need to address the issue through education, not necessarily a protocol change. Mr. Simone noted he can include the education within his agency's recertification cycle when refreshing on airway management and/or ventilation. He suggested the Committee arrive at a universal definition to be distributed to the EMS system so everyone is on the same page.

TJ Smith stated the challenge for Henderson EMS providers is in making the decision to transport a patient an additional 20-30 minutes with a BVM and OPA in place when there is the potential for gastric distension. They encountered that conundrum the prior month with a child who had blood in his airway. Adequacy of ventilation was in question, and the crew made the decision to transport to the closest facility, St. Rose Siena, which would also provide a higher level of care. Ultimately, the child was subsequently transported UMC, but the crew didn't feel that an additional 20-30 minute transport would be beneficial for the child's outcome. The Trauma Field Triage Criteria (TFTC) protocol is difficult to discern when considering appropriate facility as it pertains to location, anatomic changes, or neurological impairment. Mr. Smith asked if the issue was raised because of that particular call. Mr. Hammond asked if the crew was able to ventilate the patient. Mr. Smith replied that they were, but that there was blood in the airway and they were unable to get an advanced airway in place, so the potential for decompensation was high. Mr. Hammond noted that the entire county is almost as large as New Jersey. Although it's a challenge for Henderson, there are other agencies that respond to outside areas as well. The point is that they need to try to make the best decision for the patient. If the paramedic is uncomfortable with transporting to the closest facility, that's all right. Everyone is looking for black and white answers in a very gray world; unfortunately, it's not that easy. In that particular case, the best decision was to take the child to the closest facility. But the next case, and the case after that, may be a little different; there is no on/off answer. It still comes down to provider discretion and impression.

Dr. Anderson noted the EMS providers need a little latitude concerning the issue of adequate ventilation, and that each agency should address it through their QI (quality improvement) process. There should be simple guidelines for them to provide the best patient care. He noted that there will always be exceptions. August Corrales suggested they consider the verbiage "obstructed vs. unobstructed airway" to keep it simple. If you have an obstructed airway, for whatever reason, and you can't get the secretions out, perhaps it would be better to transport to the closest facility; but if you have an obstructed airway and can achieve ventilation without endotracheal intubation, it seems that you would be all right in that sense as well. Mr. Simone noted that the educational component should be focused solely on the inability to ventilate. He explained that if you are unable to properly ventilate the patient--if the OPA is not effective and the EMS provider indicates he/she is not able to effectively ventilate--they need to go to the closest facility.

Derek Cox asked whether there will be an educational component attached, and whether the issue needed to be referred to the QI Directors Committee. Mr. Hammond replied that EMS providers may need to be further educated with regard to the difference between "intubate" and "ventilate", but reiterated that the decision will ultimately be to use their best discretion. Mr. Simone stated it comes down to "inability to ventilate" and "inability to intubate". It will require a simple, one-page educational document to refresh their understanding of the issue. Dr. Anderson noted that if the crew is attempting to intubate, it means all their other tools have failed. There is a progression of care. At that point in time, they need to transport to the closest facility. It's simple. The Committee shouldn't even be discussing the issue. There are politics involved that don't relate to patient care, and he is sick of it. Mr. Hammond expressed concern as to Dr. Anderson's reference to the issue of politics.

Dr. Anderson stated that if intubation is the last attempt after all other procedures have failed and you're not effectively ventilating, the crew should transport to the closest facility; it's cut and dry. Mr. Hammond stated that he was not arguing that point. Dr. Anderson responded by asking why they were discussing the matter. Mr. Hammond stated the issue was placed on the agenda in response to a concern that was raised. Dr. Anderson stated that the concern was inappropriate. Mr. Hammond asked whether it was the will of the Board (Medical Advisory Board) to ignore a concern, or to issue a statement. Dr. Anderson asked if they were all in agreement the EMS provider was trying to intubate, and failed. If so, their next step was to transport to the closest facility. Mr. Hammond noted that some of the concern arose from the fact that they were determining whether or not the "ability to intubate" is "the ability to ventilate". That is the issue the Committee is attempting to establish. Dr. Anderson reiterated that the crew will escalate their measures when they encounter inadequate ventilation. When they fail at intubation, the next step is to transport to the nearest facility.

Mr. Cox asked whether the issue arose because an EMS provider thought the inability to intubate meant they should transport to the closest facility. Dr. Anderson stated that the inability to intubate is the inability to ventilate; it's the last step in the progression of care. Mr. Cox replied that it is more of an issue with definition. If the provider who is not able to intubate feels he/she must go to the closest facility, that is incorrect; it's really the inability to ventilate. He stated they may need to revise the terminology and address it in the education process. He added that they could come up with continuing education to address the inability to ventilate, and not necessarily the inability to intubate, and come up with a few scenarios so the next time the crew won't say they went to the closest facility because they were unable to intubate; it may just be a terminology issue.

Mr. Simone noted it would really be more of a simple review to ensure everyone has a clear definition of "ability to ventilate" vs. "inability to ventilate". Each agency may subsequently expand on that education as they see fit. From an education standpoint, he feels it would be a single document for the purpose of clarification. Mr. Corrales agreed the protocol is set up so that if the provider is unable to ventilate, for any reason, he/she should have the ability to go to the closest facility. He added that nobody has better eyes than the paramedic who is treating that patient, so we should trust in their discretion.

Brandie Green stated the clarification language can be taken straight out of PHTLS (prehospital trauma life support), which contains a clear definition of "inability to ventilate" vs. "inability to oxygenate" the patient. A one-page document can easily be created to refresh the providers. She noted that many of them let their PHTLS lapse and are not receiving education on the updates. The agencies can put them through the appropriate education and skills proficiency. Mr. Simone agreed that they could distribute the single-page document to the permitted agencies to include in their education classes prior to recertification. Mr. Cox asked whether the skills component was going to be mandatory. Mr. Simone replied that the single-page document would be the minimal recommendation, and the need to include a skills component would be left up to the agency.

A motion was made by Frank Simone to develop a single-page document to define "ability to ventilate" vs. "inability to ventilate" to be distributed to all permitted EMS agencies. The motion was seconded by Derek Cox and passed unanimously by the Committee.

B. Discussion of Incorporating the Monitored Instructor Hours as Part of the Instructor Course

Mr. Simone reported he has been working with the Health District to incorporate the monitored lecture and skills hours into the instructor course. He would like to form a workgroup to discuss the logistics of the process, as well as working towards incorporating the preceptor program into that course. Mr. Cox stated a workgroup would be a great place to review the Health District's monitoring form, and perhaps to discuss a separate process for secondary and primary instructor applicants.

A motion was made by Derek Cox to create a workgroup to evaluate the current instructor course and bring its recommendations back to the Education Committee. The motion was seconded by Jim Kindel and carried unanimously by the Committee.

IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY

A. Clark County Emergency Medical Care Protocols

Laura Palmer stated that questions have been brought forward to the Health District related to the pediatric age cut off. After review, the only place this information was found was in the Foreword of the protocol manual. She noted that the information has now been added to the page titled "Pediatric Treatment Protocols".

B. Update on Monitoring Form for EMS Instructor Applicant

Gerry Julian stated that the current monitoring form does not include the name of the lecture topic that is being monitored. Also, although the form asks for comments for any rating of "1" or "2", he feels a comment should be included for each given rating. This gives the instructor applicant appropriate feedback related to his performance. The impetus for revising the form was that some students were unaware they needed to be signed off on the didactic/skills component within 90 days of course completion. Students who were not advised of this requirement as part of the instructor course have been required to retake the entire course. Mr. Julian referred the Committee to Mr. Simone for additional comments.

Mr. Simone agreed with Mr. Julian that the need to include an evaluation comment for each score given is an important key to let the instructor applicant know what is expected. He noted that the current form requires a minimum of an hour each for both the lecture and skill component. An hour for teaching a skill may be a little excessive. He would like to see both timeframes removed and let the evaluating instructor determine the applicant's level of competency. In addition, he feels the lecture/skills evaluation should be included in the instructor course, as opposed to requiring the student to have them signed off within 90 days of course completion. The primary instructor who teaches the course should be the one to evaluate instructor applicants and provide appropriate feedback to ensure they walk out with a basic foundation in didactic and skills evaluation.

Mr. Cox stated there are a couple of other ideas he would like to discuss with regard to the processes for secondary and primary instructors, as their roles are different. Ms. Green asked if they discussed removing the 24-hour time requirement for the instructor course. Mr. Simone stated the time requirement is not spelled out in the procedure; it has historically been 24 hours in length.

Mr. Julian invited all interested parties to attend the workgroup and provide input as to how future instructor courses should be structured. Mr. Simone encouraged all the educators to bring their course outlines to the workgroup. They can look at the different outlines and come up with a singular outline for the purpose of providing consistency in the product they're offering to their instructor applicants. Mr. Hammond encouraged the educators to go to NEMSI's website prior to their meeting since our current system is based on their model; specifically, the framework for the Fire Instructor I and II courses.

The Committee discussed problems they are encountering with the new preceptor forms. Mr. Hammond asked the agencies to formulate their list of concerns and to forward them to Mr. Julian for further review.

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 Simone 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 Simone called for a motion to adjourn. *A motion was made by Troy Tuke, seconded by August Corrales and carried unanimously by the Committee to adjourn the meeting at 10:03 a.m.*