CLARK COUNTY HEALTH DISTRICT

MINUTES

EMERGENCY MEDICAL SERVICES

PROCEDURE/PROTOCOL COMMITTEE

February 1, 2006--2:00 P.M.

MEMBERS PRESENT

Richard Henderson, M.D., Chairman
Larry Johnson, EMT-P, MWA
Brian Fladhammer, Mercy Air
Chief David Petersen, MFR
Philis Beilfuss, R.N., NLVFD
Derek Cox, EMT-P, AMR
Thomas Geraci, D.O., MFR
Aaron Harvey, EMT-P, HFD

MEMBERS ABSENT

Jon Kingma, EMT-P, BC
Allen Marino, M.D., MWA/NLVFD
Sandy Young, R.N., LVFR
Batt. Chief Trent Jenkins, CCFD

CCHD STAFF PRESENT

Rory Chetelat, EMS Manager
Moana Hanawahine-Yamamoto, Admin Assist
Trish Beckwith, Field Representative
Mary Ellen Britt, R.N., QI Coordinator
Judy Tabat, Rec. Secretary

PUBLIC ATTENDANCE

Debra Daily, EMT-P, MedicWest Ambulance
Jerry Newman, Specialized Med Services
John Higley, EMT-P, MFR

I. CONSENT AGENDA

The Procedure/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, February 1, 2006. Chairman Rick Henderson, M.D., called the meeting to order at 2:04 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Henderson noted that a quorum was present.

Minutes Procedure/Protocol Committee Meeting November 2, 2005

Dr. Henderson asked for a motion to approve the minutes of the November 2, 2005 meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

Dr. Henderson advised the committee that the actions items on today's agenda could not be voted on because they were not placed on January's MAB consent Agenda. Therefore, those items would be open for discussion only.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion to revise the 20 minute protocol

The "General Patient Care Protocol" allows EMS personnel to place certain patients in the ED waiting room twenty minutes after arrival.

Dr. Henderson stated that the discussion was taking out the verbiage that says 20 minutes and make it become the practice to take the patient directly to the waiting room if they meet the criteria. He added that he would like to push for the IV's that are put in place in the field be left in place but have the patient sign a disclaimer. He knows that the nurses at the facilities are making EMS pull the lines because they have a concern that the patient is going to walk out with the IV line still in place which will make them liable.

Rory Chetelat stated that a form was created, but it was an informational sheet to hand to the patients. Dr. Henderson asked if it can be revised so they have to sign. Mr. Chetelat commented that he will take this to the Health Districts legal department for approval.

Dr. Geraci felt that the only thing that was missing is that they should be reporting that they are taking this patient to the waiting room. Ms. Beilfuss felt that an addendum should be placed on the PCR regarding notification of appropriate ED personnel.

Derek Cox asked if this form would be required on every patient left in the waiting room. Dr. Henderson stated this would be just for an IV patient and if they don't want to sign the IV should be removed. Mr. Cox asked who would have the responsibility of removing this IV. Dr. Henderson stated that if they are put in the waiting room they are still EMS's patient at that point.

B. Discussion on guidelines for c-spining.

Sandy Young brought three different Spinal Clearance protocols for review.

Ms. Beilfuss stated that many studies indicate that medics in the field are far more likely to err on the side of the patient and place them on a board rather than not.

Dr. Henderson commented that he is in support of a c-spine protocol and he felt that the handout was a straight forward algorithm and doesn't require any special judgment.

Brian Fladhammer stated that he worked in California and they had a c-spine clearing protocol that was fairly successful.

Mr. Cox added that what he liked about this algorithm is that the only level that could possibly clear a patient would be a paramedic and you would only want the highest level of training to be able to do that.

The consensus of the committee was to go with the first spinal clearance protocol.

C. Discussion on patient choice being the highest priority.

David Petersen brought up an issue that he felt might be a Mesquite anomaly more then anything. Under the General Patient Care Protocol section H. Disposition, item 2 it states to transport to the closest facility. He stated that their rural hospital has limited services so if they get a stroke or a cardiac patient after 7:00 p.m. there is no CT scan or cath lab available so basically the ER physician's hands are tied and they end up with a re-transport. They feel if the patient is stable already and not seeing any conditions that would warrant them needing to be seen by an ER physician right away they could get them to St. George or Las Vegas in 40 minutes.

Dr. Henderson stated that stroke patients make perfect sense but asked if he was talking about anything else besides trauma, strokes or heart.

Mr. Petersen explained that he has had complications related to OB that their hospitals is not capable of handling.

Dr. Henderson voiced his concern with an acute MI or a laboring woman and that they are calling for an interfacility transport and not calling for a critical care transport or a helicopter. He also expressed that he was concerned not just about patient care but also EMTALA.

Mr. Petersen stated this happens all the time and maybe we could look at some language that says to the closest "appropriate" facility. That decision can be in conjunction with the ER physician since we're looking at getting the latitude like we did with trauma to say under certain circumstances we believe it's in the patient's best interest medically to take them directly to a facility that can treat them immediately as opposed to taking them for stabilization and requiring another transport which prolongs access to specialized treatment.

Mr. Chetelat explained the reason the word "appropriate" was taken out of the protocol was it required a phone book of directions of what was appropriate for that day or that time so it created a whole new list of problems. He suggested language that would say to check with your local facility and base it on their unique geographic location instead of making it system wide.

Mr. Cox added that if we do it geographically as we did with the trauma then this would be the perfect opportunity to address STEMIS, cardiac alerts and strokes. The important part during the development of this is going to be objective clinical findings of how they're going to fit into this population's criterion to make it safe.

Dr. Henderson stated that we really didn't talk about patient choice and not taking them to their hospital of choice, but with the 30 minute drop rule it should be less of a factor.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

No response.

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 2:45 p.m.