MINUTES

EMERGENCY MEDICAL SERVICES

PROCEDURE/PROTOCOL COMMITTEE

May 3, 2006—10:00 A.M.

MEMBERS PRESENT

Richard Henderson, M.D., Chairman
Larry Johnson, EMT-P, MW
Philis Beilfuss, R.N., NLVFD
David Petersen, EMT-B, MFR
Robert Nichols, EMT-P, AMR
Allen Marino, M.D., MW/NLVFD
Sandy Young, R.N., LVFR
Randy Howell, EMT-P, HFD (Alternate)
Tricia Klein, EMT-P, AMR

MEMBERS ABSENT

Jon Kingma, EMT-P, BCFD
Trent Jenkins, EMT-P, CCFD
Aaron Harvey, EMT-P, HFD
Thomas Geraci, D.O., MFR
Brian Fladhammer, Mercy Air

CCHD STAFF PRESENT

Rory Chetelat, EMS Manager
Joseph Heck, D.O., Operational Medical Director
David Slattery, M.D., Asst. Operational Medical Director
Edwin Tajima, Administrative Assistant
Mary Ellen Britt, R.N., QI Coordinator
Rae Pettie, Program/Project Coordinator
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

John Higley, EMT-P, MFR
Jerry Newman, EMT-I, Specialized Medical Services
Jo Ellen Hannom, R.N., CCFD
Nicole Bachmann, Touro University
Jonathan Atkin, CCSN Student
Geoff P., CCSN Student
Tim Crowley, EMT-P, LVFR
Derek Cox, EMT-P, LVFR
Matthew Off, CCSN Student
Justin Ratliff, CCSN Student
Seth Devereaux, CCSN Student

I. CONSENT AGENDA

The Procedure/Protocol Committee convened in the Clemens Room of the Ravenholt Public Health Center on Wednesday, May 3, 2006. Chairman Rick Henderson, M.D., called the meeting to order at 10:08 a.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 April 5, 2006

Dr. Henderson asked for a motion to approve the minutes of the April 5, 2006 meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Revisions to BLS/ILS/ALS Protocols Due to Changes in AHA Guidelines

Dr. Henderson asked Dr. Heck to lead the discussion of the revisions to the BLS/ILS/ALS Protocols.

Dr. Heck started off by stating it was important to note that the Heart Association is a guideline and as such we adopt those changes that we deem to be appropriate for our system based on the practices that go on within our community in cooperation with the emergency department physicians and the practicing cardiologists.

Dr. Heck then reviewed each protocol pointing out the changes that were recommended:

- Acute Coronary Syndrome (Suspected) – To clarify intent of when Nitroglycerin should be administered; removed "chest pain" and replaced with "ischemic discomfort".

- Cardiac Arrest – Housekeeping changes using the phrase "has return of spontaneous circulation" as opposed to successful AED use. Discussed the differences between witnessed and unwitnessed arrest and implementing the (2) minutes of uninterrupted CPR in unwitnessed arrest prior to defibrillation.

- Cardiac Dysrhythmia: Asystole – Dr. Heck noted that transcutaneous pacing was removed since it was no longer recommended by the AHA; changes were made to the Atropine dose which is no longer a weight based dose; and we will continue to include Sodium Bicarbonate which is different from the Heart Association.

  Ms. Beilfuss suggested using "consider" versus "administer Sodium Bicarbonate" but Dr. Heck stated that we do want them to give this on a prolonged arrest.

- Cardiac Dysrhythmia: Bradycardia – Changes to a standard dose of Atropine.

- Cardiac Dysrhythmia: Monomorphic Ventricular Tachycardia – Removed the telemetry requirement for cardioversion in the pediatric patient; made the changes from Versed to Etomidate for sedation; put in the opportunity to reassess for additional sedation prior to further cardioversion and added a repeat dose of Amiodarone as opposed to Lidocaine. Dr. Heck also noted that since Amiodarone was put in instead of Lidocaine, the Lidocaine continuous intravenous infusion was removed.

  Dr. Marino questioned whether the pediatric community was in agreement with the Etomidate. Dr. Heck stated that he has attempted to make contact with the pediatric community to no avail.

- Cardiac Dysrhythmia: Pulseless Electrical Activity – The substantive change was the Atropine dose.

- Cardiac Dysrhythmia: Supraventricular Tachycardia (Narrow Complex) – The pediatric dose of Adenosine was added; changed the sedation from Versed to Etomidate and deleted the use of Amiodarone for SVT.

Ms. Beilfuss asked the reason for dropping the Amiodarone from the SVT. Dr. Heck advised that after discussions with the cardiologists in a narrow complex tachycardia, there is no indication for Amiodarone.

- Cardiac Dysrhythmia: Torsades De Pointes – Removed the telemetry requirement for hemodynamically unstable cardioversion; made the change from Versed to Etomidate and removed Lidocaine and just solely using Magnesium.

- Cardiac Dysrhythmia: Ventricular Fibrillation or Pulseless Ventricular Tachycardia – Made changes for witnessed and unwitnessed cardiac arrest and the (2) minutes of CPR in the unwitnessed arrest; Amiodarone in lieu of Lidocaine which would make the 1st dose at 300 mg IV and the 2nd dose would be 150 mg IV. Dr. Heck explained that the 3rd dose in renumbered #8 will be deleted along with renumbered #9.

- Defibrillation – Reflects the changes for witnessed and unwitnessed cardiac arrest and (2) minutes of CPR prior to defibrillation in the unwitnessed arrest.

- Synchronized Cardioversion – Dr. Heck stated that the two paragraphs under #6 regarding pediatric cardioversion will be deleted. They were put in new for clarification but it made it more confusion so they will be removed.

- Formulary – The respective changes that reflects what was done in the treatment protocols will be made.

Dr. Heck stated one protocol was not included in the handouts and needed to be discussed; the ventricular ectopy protocol. He stated that the Heart Association does not have a protocol for treating ventricular ectopy so it was his recommendation to pull the entire protocol. He added the treatment for ventricular ectopy is Lidocaine and since Lidocaine has been taken out of every other ventricular dysrhythmia protocol and the AHA no longer treats ventricular ectopy we should delete this protocol. The only place that Lidocaine appears in any of the protocols is in the advanced airway for the pre-medication of the head injured patient upon intubation.

Ms. Beilfuss questioned whether they would be able to remove the Lidocaine drips out of the inventory.

Dr. Heck stated that if we pull the ventricular ectopy protocol then the Lidocaine drips can be removed.

Dr. Henderson asked if the literature to support Lidocaine for intubation was strong enough to continue carrying Lidocaine.

Dr. Slattery added probably not because you need to have 2 or 3 minutes before you intubate.

Dr. Heck stated that not only will we recommend to delete the ventricular ectopy protocol we will also recommend removing the use of Lidocaine from the advanced airway protocol and subsequently remove all Lidocaine from the inventory.

Randy Howell asked about the time frame on rolling out these revised protocols. Dr. Heck advised that his goal is to have a revised protocol manual out in July.

Ms. Beilfuss questioned whether there were any issues with the medics starting to use the 30 to 2 CPR ratio in the field settings. Dr. Marino stated that once the medics get their BLS recertification they use the skills. Dr. Heck added that is why we talk about it as CPR and don't describe specific steps. Do CPR like you're trained to do CPR.

A motion was made to approve the recommended changes and modifications as discussed. The motion was seconded and passed unanimously.

B. Discussion of Revisions to Prehospital Death Protocol

Dr. Slattery stated there is some vagueness in the current prehospital death determination protocol and he is recommending some changes which are supported by a position paper by NAEMSP which outlines the evidence behind these changes. He then explained to keep the prehospital death determination separate from the termination of resuscitation protocol which has been encapsulated into one protocol for our system even though they are two different decision tools. Dr. Slattery then pointed out the changes made to the protocol:

- In section 1a, item 5 No electrical activity present on cardiac monitor was added as the 5th presumptive signs of death that must be present and removed from conclusive signs of death.
- In section 1b, Conclusive signs of death include: - Except for real true signs of death like lividity, rigor mortis and body decomposition he felt penetrating head or neck injury and arrest from severe blunt trauma were very vague so he specifically spelled out the injuries incompatible with life which are decapitation, transection of the thorax and incineration. Dr. Slattery went on to say that he feels every patient at least deserves a trial of resuscitation but added not necessarily transported.
- In section 2, hypothermic patients will be resuscitated.

Dr. Slattery stated that in the termination and resuscitation portion of the protocol, there is a method and mechanism for termination of resuscitation so the changes that were made would be to specify the amount of time the resuscitation with ACLS care will be performed on scene. If the patient remains in persistent asystole or agonal rhythm after (20) minutes of appropriate ALS resuscitation to include:

- CPR
- Effective ventilation
- Ability to administer medications (successful IV access or endotracheal intubation)
- Administration of appropriate ACLS medications
- Needle Thoracentesis for traumatic arrest

Then EMS personnel can call a code with a physician order.

In section 5b, item # 3, injuries incompatible with life was removed because that was vague.

Dr. Henderson questioned the use of endotracheal medications since ACLS stated they were ineffective. Ms. Beilfuss stated that it was still an acceptable practice but has been discouraged if you can get an IV or and IO route. Dr. Heck added stated that since the Heart Association still has the reference to endotracheal drugs in their protocols it's still an alternative route.

Dr. Marino added that since ACLS spells out IV and IO, line 3 would not be necessary since line 4 is administration of appropriate ACLS medications. Dr. Heck agreed and stated that line 3 will be deleted.

Sandy Young asked whether there would be any differentiation between adult or pediatric. Dr. Slattery stated that this is all done with a physician order so this would be kept the same for all patients. Mr. Howell added that a telephone icon needs to be added to item 5.

Ms. Young asked if another heading between prehospital death and termination of resuscitation should be added to this protocol or create a separate protocol. Dr. Slattery and Dr. Heck both agreed it would be better to make two separate protocols.

A motion was made to approve the recommended changes and modifications as discussed. The motion was seconded and passed unanimously.

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 10:39 a.m.