



**MINUTES**

**EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM**

**DIVISION OF COMMUNITY HEALTH**

**DRUG/DEVICE/PROTOCOL (DDP) COMMITTEE**

**February 6, 2019 – 9:00 A.M.**

**MEMBERS PRESENT**

Mike Barnum, MD, AMR, Chairman  
Jessica LeDuc, DO, HFD  
Chief Troy Tuke, CCFD  
Karen Dalmaso-Hughey, AMR  
Shawn Tobler, MFR  
Mark Calabrese, CCFD  
Shane Splinter, HFD  
Jim Kindel, BCFD

David Slattery, MD, LVFR (via phone)  
Jeff Davidson, MD, MWA  
Jarrod Johnson, MD, MFR  
Michael Holtz, MD, CCFD  
Chief Kim Moore, HFD  
Derek Cox, LVFR  
Steve Johnson, MWA  
Corbin King, Mercy Air

**MEMBERS ABSENT**

K. Alexander Malone, MD, NLVFD  
Scott Scherr, MD, GEMS  
L. Cole Sondrup, MD, CA  
Chelsea Monge, CA

Matthew Horbal, MD, MCFD  
Frank Simone, NLVFD  
Paul Stepaniuk, HFD  
Steven Carter, AMR

**SNHD STAFF PRESENT**

John Hammond, EMSTS Manager  
Scott Wagner, EMSTS Field Representative  
Judy Tabat, Recording Secretary

Christian Young, MD, EMSTS Medical Director  
Gerry Julian, EMSTS Field Representative

**PUBLIC ATTENDANCE**

Jason Driggars  
Stephanie Teague  
Brett Olbur  
Johnny Foy

Sam Scheller  
August Corrales  
Tony Greenway  
Chief Jon Stevenson II

**CALL TO ORDER - NOTICE OF POSTING OF AGENDA**

The Drug/Device/Protocol Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday, February 6, 2019. Chairman Mike Barnum called the meeting to order at 9:14 a.m. The Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Barnum 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 Mike Barnum asked if anyone wished to address the Board pertaining to items listed on the Agenda. Seeing no one he closed the Public Comment portion of the meeting.

## II. CONSENT AGENDA

Chairman Barnum 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.

Approve Minutes for the Drug/Device/Protocol Committee Meeting: December 5, 2018

Chairman Barnum asked for a motion to approve the December 5, 2018 minutes of the Drug/Device/Protocol Committee meeting. A motion was made by Troy Tuke, seconded by Steve Johnson and carried unanimously to approve the minutes as written.

## III. REPORT/DISCUSSION/POSSIBLE ACTION

### A. Review/Discuss Behavioral Emergencies Protocol

Scott Wagner stated a concern was brought up with regards to the current protocol that directs EMS providers to restrain every behavioral emergency patient who threatens or acts in a way that suggests threat to self or others. In addition, there was a question as to the specificity of using 2- and 4-point restraints. Mr. Wagner stated that mental health patients who are placed in restraints and subsequently transported from the ER to a mental health facility are being turned away. Mr. Calabrese acknowledged that CCFD has encountered behavioral patients who have called 911 and stated they wanted to harm themselves, but they are calm and just want to go to a hospital. However, once they are placed in restraints they are not happy and usually end up creating a scene in what could have been a gentle ride to the hospital. Brett Olbur stated he experienced a similar event where an 8-year old texted "I want to kill myself" to his parents. The patient was calm and cooperative, but they had to use restraints per protocol. He agreed that the need for restraints unnecessarily can escalate the situation. Dr. Davidson mentioned that the mental health patients either de-escalate and they remove the restraints quickly or escalate and require either medication or sedation before the restraints can be removed. He noted he would prefer that no one get hurt in the field.

Chief Tuke stated they trust EMS providers with making good judgments based on their field experience. He recommended they change the language to "consider" restraints. Mr. Driggars expressed concern with "consider" because it may present an unnecessary dangerous situation, especially with the new hires. Some EMS providers may not realize that they should be using the restraints until they've been assaulted once, or until a patient lopes out of a moving ambulance. The confined space in the back of an ambulance presents an increased danger as opposed to an ER setting. He stressed the need to carefully consider making it optional. Mr. Olbur stated Dignity Health's policy is that if the patient is not restrained in the hospital they shouldn't be restrained when being transported. Dr. Young clarified that a medically cleared patient means they don't have a medical condition that is precluding their psychiatric assessment; it is not saying they are not a threat to themselves or others. When they are medically cleared they are placed on a certification. That's probably the reason why they're being transported.

Sam Scheller stated that non-emergency transport agencies provide transport from the ER to a mental health facility. He asked whether they would be precluded from providing those transports. Mr. Driggars noted that non-emergency transports are not governed by SNHD so their policies would remain dependent of any decisions made by this body.

Mr. Calabrese asserted that each agency should be given the flexibility to use restraints or not. Agencies can adopt their own organizational policies as they see fit.

Jarrod Johnson made a motion to revise the Behavioral Emergency protocol to read, "Consider 2- or 4-point restraints" when a patient threatens or acts in a way that suggests threat to self or others. The motion was seconded by Chief Tuke.

Dr. Holtz questioned why the protocol does not include the choice of 4-point restraints for a patient who threatens to harm others. Mr. Splinter remarked that the decision to use 2- or 4-point restraints should be made based on the level of threat. Dr. Young proposed they change the language to read, "Consider behavioral restraints." Chief Tobler asked if there are types of restraints in excess of 4-point that we don't want the agencies to use. Dr. Davidson stated that all EMS providers know how to use restraints. He recommended they keep the

educational component out of the protocol as the agencies should cover it in training. Dr. Holtz questioned why “No prone position” is included in “threatened to harm others” and not “threatened to harm self.” In addition, “consider law enforcement” is included in “threatened to harm self” and not “threatened to harm others.” The committee agreed that both boxes should have the same verbiage.

Chief Tuke rescinded his original motion and made a new motion to make the following revisions to the Behavioral Emergency protocol:

1. Under “Threatened to harm SELF:” “Consider behavioral restraints; consider law enforcement escort; NO PRONE POSITION.”
2. Under “Threatened to harm OTHERS:” “Consider behavior restraints; consider law enforcement escort; hood if indicated; NO PRONE POSITION.”

The motion was seconded by Ms. Dalmaso-Hughey and carried unanimously.

Dr. Slattery remarked that Ketamine is listed for use for patients who threaten to harm others and continue to be a persistent risk. He noted that it should only be used for Excited Delirium. He suggested they move it as a separate branch point under Excited Delirium. After much discussion, Dr. Slattery agreed to work with the OEMSTS and bring the draft language to the next meeting for consideration by the committee.

B. Review/Discuss Use of Epinephrine in Adult/Pediatric Shock and Allergic Reaction Protocols

Mr. Wagner stated that discussion took place at the last meeting about the fourth pearl on the adult and pediatric Allergic Reaction protocols that reads “Anaphylaxis refractory to repeat doses of IM Epinephrine may require IV Epinephrine (1:10,000) administration by IV push” is irrelevant with the addition of push dose Epinephrine.

Mr. Wager explained that the adult and pediatric Shock protocols were brought back for further discussion on whether to add a pediatric maximum dose. Mr. Splinter remarked that the pediatric push dose Epinephrine exceeds the adult maximum dose. Dr. Holtz related that the correct dosing for pediatrics is weight-based, with no maximum indicated. Mr. Splinter explained they brought the question forward in response to questions from the EMS providers. Dr. Holtz replied that he can see how it would be concerning to people who are not used to it, as it is counter-intuitive. He offered to send the literature to the committee. Dr. Barnum stated that that would be appreciated and that it can be placed on the next agenda as an information item.

Dr. Holtz noted there is a weight-based dosing on the Allergic Reaction protocol, but not on the Shock protocol. He suggested they bring the two protocols into compliance. If you have a patient in extremis, whether it is undifferentiated shock or allergic reaction, it should be the same. Also, there should be a weight-based dosing for pediatric patients. Dr. LeDuc recommended they ensure there isn’t a true pediatric maximum dose. Mr. Wagner stated he would revise the language to bring the two protocols into conformity for discussion at the next meeting.

C. Review/Discuss Use of Nitroglycerin in Adult Chest Pain and STEMI (Suspected) Protocols

Mr. Wagner requested a housekeeping change to both protocols for the administration of Nitroglycerin.

Dr. LeDuc made a motion to revise the Nitroglycerin dosing in both the adult Chest Pain (Non Traumatic) and Suspected Acute Coronary Syndrome and Stemi (Suspected) protocols to read, “0.4 mg SL; May repeat q 5min x2.” The motion was seconded by Chief Tuke and carried unanimously.

D. Review/Discuss the Following Protocols: Prehospital Death Determination; Termination of Resuscitation

Dr. Slattery remarked that the EMS providers need guidance with respect to the Prehospital Death Determination (PDD) and Termination of Resuscitation (TOR) protocols. The committee previously agreed to include 1.E. “Functional separation from the body of the heart, brain, or lungs” as an obvious sign of death. Traumatic injury has been problematic because those patients won’t have dependent lividity or rigor mortis. They also added #5 to include traumatic and non-traumatic arrest under presumptive signs of death. He gave the example of responding to a patient with a gunshot wound to the chest. The patient is pulseless, apneic, and unresponsive and the EMS provider does not know if they have fixed or dilated pupils. The expectation is that the patient does not meet PPD per the protocol, so the EMS provider would open the airway and ventilate because the patient has a penetrating

wound to the chest. The only reversible condition that can make a difference is to perform a chest thoracostomy on that patient, and if no response, call for TOR orders. If the patient has an organized rhythm greater than 40, that patient should receive full resuscitation efforts and be taken to the trauma center. That decision making is consistent with the best consensus guidelines available nationally from both the National Association of EMS Physicians and the American College of Surgeons. His suggested they move 5.B. "For Traumatic Arrest: no organized rhythm or a PEA <40" from the PDD protocol to 2.B.4 of the TOR protocol as a criterion for considering TOR in a traumatic arrest. If it's a traumatic arrest with rigor mortis and lividity, then that patient still fits the criteria. But in the absence of functional separation from the body of the heart, brain, or lungs, it would be more congruous in the TOR protocol.

Dr. Barnum suggested they remove "of any degree" with regards to both lividity and rigor mortis as it is an educational component. The committee also made additional housekeeping changes.

A motion was made by Dr. Slattery to make the following revisions to the draft Prehospital Death Determination and Termination of Resuscitation protocols:

1. Add E. "Functional separation from the body of the heart, brain, or lungs" to the PDD protocol.
2. Remove 5.B. "For Traumatic Arrest: no organized rhythm or a PEA <40" from the PPD protocol and move it to 2.B.4 on the TOR protocol.
3. Renumber 5.A. as 5 on the PDD protocol.
4. Revise the PDD protocol to reflect five (5) presumptive signs of death instead of four (4).
5. Revise 2.B.2. on the TOR protocol to read, "Provide CPR with effective ventilations with 100% oxygenation for two (2) minutes."
6. Remove "of any degree" from C.1. and C.2. on the TOR protocol.

The motion was seconded by Dr. Holtz and carried unanimously.

E. Review/Discuss Use of Ketamine for Sedation in Endotracheal Intubation

Mr. Wagner referred the committee to the draft Endotracheal Intubation protocol. He stated two indications were added: 1) Inability to maintain airway patency; and 2) Prediction of poor clinical course. Ketamine was also added for patient sedation at 2 mg/kg IV or 4 mg/kg IM.

Dr. Young noted that "prediction of poor clinical course" is vague in terms of the role of the transport. EMS providers know the care plan on an interfacility transfer, but it may be more difficult to ascertain for the average scene call. After considerable discussion the committee agreed not to include it under Indications and to cover it in education.

Chief Tuke made a motion to accept the revisions made to the draft Endotracheal Intubation protocol, which the exception of D. "Prediction of poor clinical course." The motion was seconded by Dr. Davidson and carried with one vote in opposition.

Dr. Holtz stated that the addition of Ketamine for sedation is an excellent idea. The committee discussed the need for repeat doses.

A motion was made by Chief Tuke to accept the addition of Ketamine for sedation, with an additional requirement to contact medical control for repeat doses. The motion was seconded by Ms. Dalmaso-Hughey and carried unanimously.

F. Review/Discuss Development of a Protocol for the Use of Metaclopramide (Reglan) and Prochlorperazine (Compazine) as Alternative Medications for Ondansetron (Zofran)

Tabled until next month. Dr. Davidson and Steve Johnson will work on the formulary and related protocols. They will also submit a Petition for Addition/Change/Removal of Drug/Equipment to/from the EMS Inventory.

G. Review/Discuss Development of a Protocol for the Use of Dexamethasone (Decadron) and Methylprednisolone (Solumedrol) as Alternative Medications for Benadryl

Tabled until next month. Dr. Davidson and Steve Johnson will work on the formulary and related protocols. They will also submit a Petition for Addition/Change/Removal of Drug/Equipment to/from the EMS Inventory.

H. Review/Discuss Development of a Protocol for Acetaminophen and Other Non-Opioid Alternatives for Pain Management

Chief Tuke remarked that studies have been done showing IV Acetaminophen has the same efficacy with less side effects than many opioids. He referred the committee to both the draft formulary and Pain Management protocol and stated that CCFD would like to do a trial to see if the literature is accurate. He proposed adding IV Acetaminophen to the Pain Management protocol for adults only. Dr. Holtz stated it would be used for adults 13 years of age or older who weigh more than 50 kg. Chief Tuke stated that if the concept is approved he will speak to the vendors and research all related costs. Dr. Davidson noted that anesthesiologists give IV Tylenol for post-operative patients with very positive results.

*A motion was made by Chief Tuke to allow CCFD to trial the use of IV Acetaminophen for pain management, and to accept the addition of IV Acetaminophen to both the formulary and Pain Management protocol. The motion was seconded by Mr. Johnson and carried unanimously.*

**IV. INFORMATIONAL ITEMS/ DISCUSSION ONLY**

Dr. Johnson asked for clarification in the situation where EMS providers who have started resuscitation efforts in the field are presented with a valid DNR or POLST. Mr. Hammond stated that 450B states that except as otherwise provided in subsection 2, a person who administers emergency medical services shall comply with the DNR/POLST protocol when the person observes the DNR/POLST identification. Dr. Johnson recommended they add language to the DNR/POLST protocol to let EMS providers know they are not required to call for orders to terminate that resuscitation. Dr. Johnson agreed to draft language to that effect and bring it to the next meeting for further discussion.

**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 included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Dr. Barnum asked if anyone wished to address the Board. Seeing no one he closed the Public Comment portion of the meeting.

**ADJOURNMENT**

There being no further business to come before the Committee, Chairman Barnum called for a motion to adjourn. *A motion was made to adjourn the meeting at 11:14 am.*