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 (DDP) COMMITTEE

December 4, 2024 – 9:00 A.M.

MEMBERS PRESENT

Kelly Morgan, MD, Chair
Jessica Leduc, DO, HFD
Jeff Davison, MD, MW
Chief Kim Moore, HFD
Jerad Eldred, MD, NLVFD
Sean Collins, CCFD
Stacy Pokorny, MWA
Chief Shawn Tobler, MFR
Jim McAllister, LVMS
Chief Shawn Tobler, MFR
Chief Brian Young, MVFD (Alt)
Mike Barnum, MD, AMR
Michael Holtz, MD, CCFD
Chief Jennifer Wyatt, CCFD
Aric Seal, NLVFD (Alt)
Nate Jenson, DO, MFR
Todd Ford, HFD
David Obert, DO, CA
Derek Cox, LVFR
Capt. James Whitworth, BCFD
Michael Whitehead, AMR
John Osborn, CA

MEMBERS ABSENT

Alicia Farrow, Mercy Air
Troy Biro, Guardian Flight
Sydni Senecal, OptimuMedicine
Jason Heck, GEMS

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Christian Young, MD, EMSTS Medical Director
Stacy Johnson, EMSTS Regional Trauma Coordinator
Roni Mauro, EMSTS Field Representative
Kristen Anderson, EMSTS Senior Admin. Assistant
Laura Palmer, EMSTS Supervisor
Edward Wynder, Associate General Counsel
Dustin Johnson, EMSTS Field Representative
Rae Pettie, Recording Secretary

PUBLIC ATTENDANCE

Sandra Horning, MD
Erik Grismanauskas
Braiden Green
Rebecca Carmody
William Vance
Debra Dailey
Ryan Young
Tony Greenway
Michael Schafer
Kat Fivelstad, MD
Matthew Dryden
Aaron Goldstein
Sarita Lundin
Nicole Brown
Brett Olbur
Kady Dabash-Meininger
Bryce Wilcox
Alexander Turner

I. CALL TO ORDER AND ROLL CALL

The Drug/Device/Protocol (DDP) Committee convened in the Red Rock Conference Room at the Southern Nevada Health District on Wednesday December 4, 2024. Chairman Kelly Morgan, MD, called the meeting to order at 9:07 a.m. and stated the Affidavit of Posting was posted in accordance with the Nevada Open Meeting Law. Some committee members joined the meeting via teleconference. Laura Palmer, EMSTS Supervisor, noted that a quorum was present.

II. DIRECTIONS FOR PUBLIC ACCESS TO MEETINGS

Members of the public may attend and participate in the Drug, Device, and Protocol Committee meeting over the telephone by calling (415)655-0001 and entering access code 2556 178 0455. To provide public comment over the telephone, please press *3 during the comment period and wait to be called on. To provide public comment over Webex, please click on the hand icon to raise your hand during the comment period and wait to be called on.

III. FIRST PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Morgan asked if anyone wished to address the Board concerning items listed on the agenda. Seeing no one she closed the public comment portion of the meeting.

IV. ADOPTION OF THE DECEMBER 4, 2024 AGENDA

A motion was made by Mr. Cox, seconded by Mr. Seal, and carried unanimously to adopt the December 4, 2024 Agenda as written.

V. CONSENT AGENDA

Items for action to be considered by the Drug/Device/Protocol Committee which may be enacted by one motion. Any item may be discussed separately per Committee Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes November 6, 2024 Drug/Device/Protocol Committee Meeting ***(for possible action)***

A motion was made by Mr. McAllister, seconded by Chief Tobler, and carried unanimously to approve the Consent Agenda.

VI. REPORT / DISCUSSION / ACTION

A. Discussion and Recommendation to Approve the Addition of a Restraints Protocol and Revise the Adult and Pediatric Behavioral Emergency Protocols

Dr. Holtz apologized for not providing the OEMSTS with an updated working draft. He stated that at the previous meeting the committee requested a revision be made to allow only two-limb restraints at a time. He noted that this procedural protocol is an important addition to the protocol manual, especially given the dangers of improper restraint. The protocol includes well laid-out guidelines and management on safe restraint policy. It also provides protection for our field providers, especially when they're confronted with other services that may prefer to restrain patients in an unsafe manner.

Chief Wyatt suggested we advise the police department about our training, so everyone is aligned. She stated that due to recent litigation, Metro is less inclined to put a patient on a mental health hold or go hands on. She feels it's important to include the deputy chiefs of operations once the protocol is put in place, and to explain to them that this is not a unilateral protocol, but more of a guideline.

Dr. Morgan asked if the DDP wanted to include an indication for releasing the restraints into the protocol. Dr. Barnum agreed, but stated they need to be careful because in these situations it could be difficult to restrain a patient that was previously restrained, when you're with them alone in the back of the moving ambulance. After

some discussion the committee agreed to add verbiage under Key Procedural Considerations to include indications for removal of restraints and the decision to do so would be at the EMS provider's discretion.

A motion was made by Dr. Holtz, seconded by Mr. Seal, and carried unanimously to accept the draft Patient Restraint protocol with the following revisions:

1. *Under "Key Procedural Considerations" revise the bullet point to read, "Apply restraints to the extent necessary to allow treatment of, and prevent injury to, the patient. Under-restraint may place both patient and clinician at greater risk. Restraints may be applied to all four extremities, or both upper extremities, or to one upper and one lower extremity."*
2. *Under "Key Procedural Considerations" add a bullet point to read, "Consider de-escalation of restraints if appropriate in the judgment of the EMS clinician."*
3. *Under "Key Procedural Considerations" revise the last sentence to read, "Apply ECG, Sp02 and EtCO2 monitors if available."*
4. *Change of title from "Documentation" to "QI Metrics".*

Mr. Hammond noted he would like the committee to discuss a bullet point on the Behavioral Emergency protocol that states, "Patients expressing suicidal or homicidal ideation or who are otherwise a danger to themselves, or others may not refuse transport. Contact law enforcement if necessary to initiate legal hold." He stated he will consult with SNHD's legal counsel on this issue. It was agreed the issue should be forwarded to the ED/EMS Committee to address, and to include Metro to ensure consistency within the spirit of the law.

B. Discussion and Recommendation to Approve the Use of Acetaminophen at the EMT Level

Dr. Morgan referred the committee to the draft adult Pain Management protocol and stated the proposal is to change PO Acetaminophen, an over-the-counter medication as an EMT level drug. Dr. Holtz questioned why the dosing was listed as "up to 1000 mg." He stated it is ambiguous and not appropriate as it needs to be either weight-based or solid. After some discussion it was agreed dosing should be Acetaminophen 325 mg – 1g PO at the EMT level for the adult Pain Management dosing, and add a max single dose of 1g for the PO pediatric pain management dosing.

A motion was made by Dr. Morgan, seconded by Mr. Seal, and carried unanimously to make the following revisions to the adult/pediatric Pain Management protocols:

1. *Change the adult Acetaminophen PO dose to 325 mg - 1gm, and make it an EMT level medication; and*
2. *Revise the pediatric Acetaminophen PO dose to a max single dose of 1g.*

Dr. Horning noted the recommendation for morphine is .05 mg/kg because most children are opiate naive and we've found that we're giving too much. Mr. Hammond stated we can place this issue on a future agenda for discussion.

C. Discussion and Approval of the Recommendation to Revise the Adult Pain Management, Electrical Therapy: Synchronized Cardioversion and Electrical Therapy: Transcutaneous Pacing Protocols

Dr. Holtz stated there was a desire to revise the verbiage for Morphine for analgesia. The current verbiage reads, "May repeat every 10 minutes until pain is relieved or respiratory/mental status depression occurs." He noted they are probably all in agreement that that is not the best practice, and the suggested change is, "May repeat dose after 10 minutes." He noted they will use the same verbiage throughout the protocol manual where this drug applies. For now, they are focusing on these two protocols. He related that he has found himself inclined to refuse those orders, so it seems appropriate to include it in protocol. The idea would be to give ketamine in addition to an opiate medication, so you shouldn't choose fentanyl, then morphine, and then dilaudid in the same patient, but if you want to give an opiate plus ketamine after an appropriate time interval, I think that would be appropriate. Dr. Eldred asked if anyone gave ketamine as their primary first choice drug. Dr. Holtz stated he has seen ketamine given as a first option. He sees no problem with giving ketamine first if that is what's available and what is wanted. There is also the implication that if there are future drug shortages, there may be issues with obtaining fentanyl. Dr. Davidson noted it's a sub-dissociative drug, and there's a small population where ketamine may be the first drug of choice for typical vascular headaches. People stay away from opiates for all the literature reasons. They will go to some of the other medications like droperidol and ketamine; the medics tend to pick up on that practice. Dr. Holtz noted there are also some patients that state they have a history of opiate addiction and don't want an opiate, so it's great we have ketamine as an option. He stated he will work on the verbiage for the next meeting to create a standing order.

Dr. Morgan stated that by definition, you pace a patient because they're clinically unstable. It's a patient who is not perfusing well, and likely has a diastolic blood pressure far below 90. She suggested they remove the sedation for that patient. She feels it's 100% reasonable to treat pain, but not sedate because they're now more conscious. She stated we shouldn't be sedating a patient that is now more awake because you're pacing an unstable patient; removing the sedation is more reasonable, unlike cardioversion, which everybody has agreed is not the most comfortable of procedures. Dr. Holtz agreed with removing Etomidate from the transcutaneous pacing protocol.

A motion was made by Dr. Holtz, seconded by Mr. Seal, and carried unanimously to remove Etomidate from the Electrical Therapy/Transcutaneous Pacing protocol for sedation; and to revise the adult Pain Management protocol under Morphine to read, "may repeat dose after 10 minutes" and add that same verbiage to the Electrical Therapy/Transcutaneous Pacing and Electrical Therapy/Synchronized Cardioversion protocols.

VII. BOARD REPORTS

Dr. Morgan stated she will be providing information on additions to the Obstetrical Emergency protocol to address pre-eclampsia and hypertension. She encouraged everyone to provide input prior to the February meeting.

Dr. Holtz reported CCFD is moving forward with their whole blood pilot. They are hopeful to begin within the next couple months. Once started, they will provide a draft protocol which will be distributed to the group. Mr. Cox noted that the FDA approved blood products in the prehospital setting. Mr. Hammond recommended that during their pilot study, they include all appropriate documentation because NHTSA is looking for research information on the use of whole blood in the field.

VIII. SECOND PUBLIC OPINION

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Dr. Morgan asked if anyone wished to address the Board regarding items listed on the agenda.

Dr. Horning stated that the pediatric Behavioral Emergency protocol is a little confusing because it states "consider a benzodiazepine IM" and then on the back it states NOT to use Midazolam, which is a benzodiazepine, and there are perhaps some better choices. She offered to take it to her colleagues and bring it back for consideration.

Mr. Cox noted it was noted in the Education Committee that we need to ramp up our education/training on preceptor methodologies.

IX. ADJOURNMENT

There being no further business to come before the Committee, the meeting was adjourned at 9:55 a.m.