Updates from EMS Symposium and Consensus Meeting in Korea (Aug 2011)

Marcus Ong
Chair, Asian EMS Council

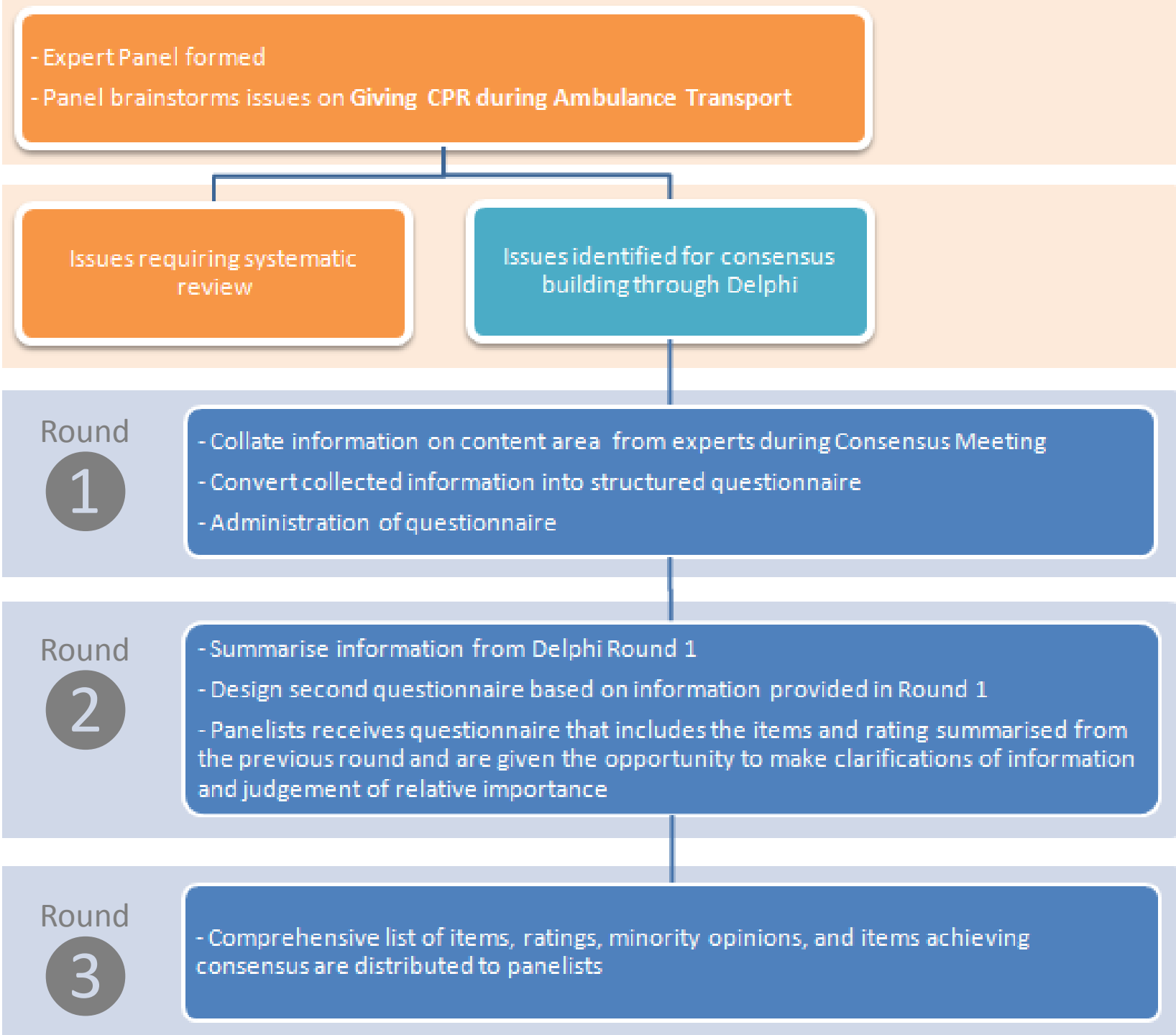
Background

Organised by	Asian EMS Council, PAROS Clinical Research Network
Supported by	Korean Council of EMS Physicians
Endorsed by	National Association of EMS Physicians
Date	23 – 24 Aug 2011
Venue	Seoul

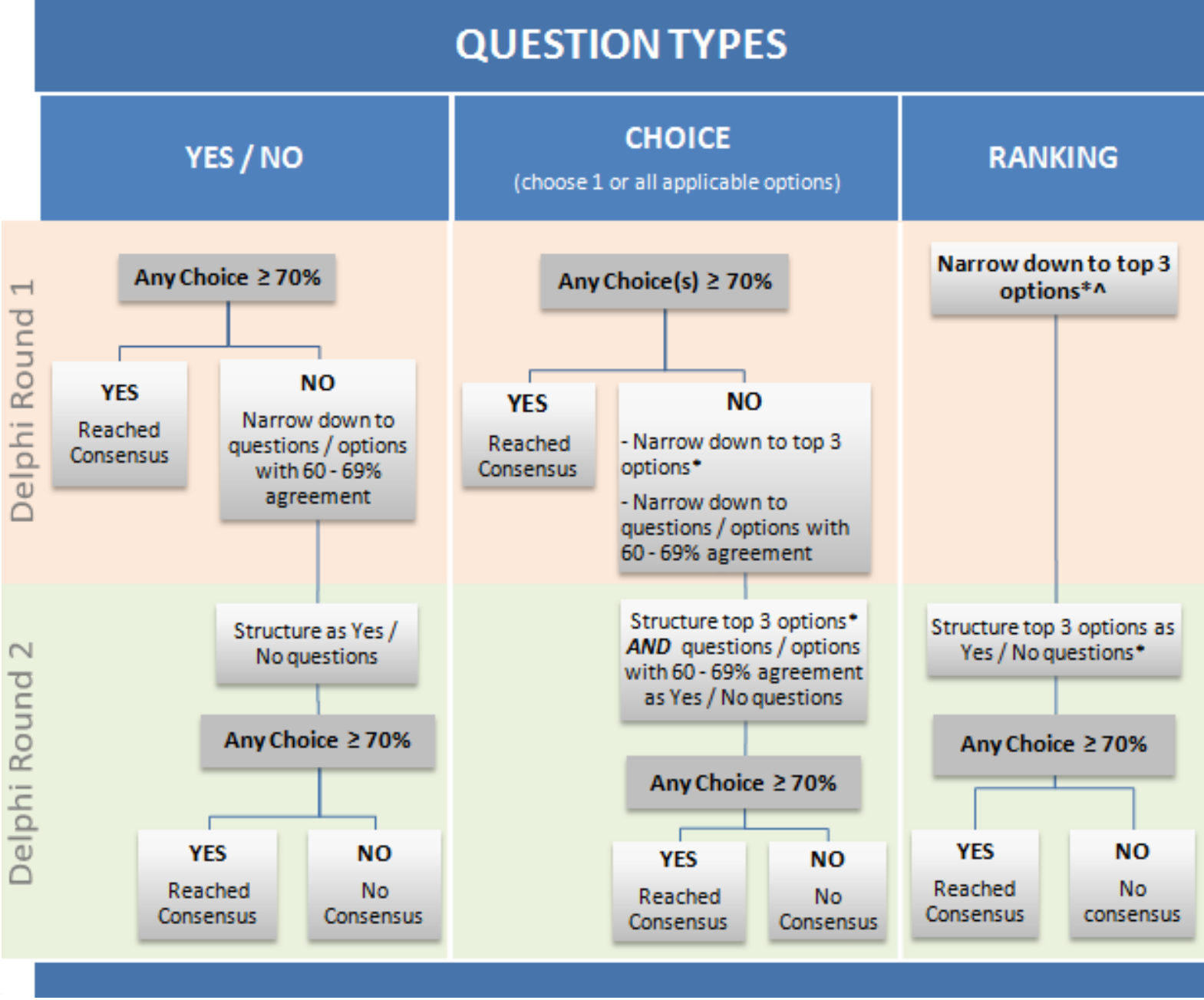
Goal

To make consensus and guidelines on giving CPR during ambulance CPR

Process


- Expert Panel formed
- Panel brainstorms issues on Giving CPR during Ambulance Transport
Issues requiring systematic review
Issues identified for consensus building through Delphi
Round 1
- Collate information on content area from experts during Consensus Meeting
- Convert collected information into structured questionnaire
- Administration of questionnaire
Round 2
- Summarise information from Delphi Round 1
- Design second questionnaire based on information provided in Round 1
- Panelists receives questionnaire that includes the items and rating summarised from the previous round and are given the opportunity to make clarifications of information and judgement of relative importance
Round 3
- Comprehensive list of items, ratings, minority opinions, and items achieving consensus are distributed to panelists

Evaluation Algorithm



* If there are two or more options ranked first or third, only the top two options will be considered for Yes / No questions in the following round of survey

^ For ranking questions, the narrowed down options will be determined using the median, and mean if required

Prelim Consensus

CONSENSUS STATEMENTS	No. of Respondents in Agreement (%)
(A) Opinion on Length of Time Crew Stays on Scene	
i The decision that drives the length of time crew stays on scene should be driven by protocol, rather than by time.	16 (80.0)
ii Advanced airways such as endotracheal intubation (ETI) and supraglottic airway should be established at scene prior to transport.	ETI: 14 (70.0) SGA: 18 (90.0)
(B) Opinion on On-Scene Interventions and Termination of Resuscitation	
i CPR, defibrillation, mechanical cardiopulmonary resuscitation (CPR) and supraglottic airways are considered effective interventions for out-of-hospital cardiac arrest (OHCA) in the field.	CPR: 20 (100) Defib: 20 (100) Mech: 16 (80.0) SGA: 15 (75.0)
ii Online medical control is useful for decision for on-field termination of resuscitation (TOR) decision.	16 (80.0)

Prelim Consensus

CONSENSUS STATEMENTS		No. of Respondents in Agreement (%)	
(C)	**Opinion on Transport of Cardiac Arrest Patient**		
i	Cardiac Arrest patients should be transported to a specialty hospital or cardiac arrest centre, rather than to any nearest hospital.	18	(90.0)
ii	Availability of pre-hospital interventions, assurance of good quality EMS care/training/skills, clinical prognosis, and social/cultural context & acceptability of on-field TOR should be used to guide decision to transport cardiac arrest patient prior to return of spontaneous circulation (ROSC).	Pre-hosp: 20 EMS care: 20 Clin prog: 18 Social: 17	(100) (100) (90.0) (85.0)
iii	Paramedics, rather than Physician, EMT-B, EMT-I or Nurse, should staff ambulance.	Paramedic: 16	(80.0)
(D)	**Opinion on Quality of Procedures Administered in Ambulance**		
i	Mechanical CPR is a better alternative to manual CPR in ambulance.	20	(100)
ii	The engine should not be turned off when analysing rhythm.	15	(75.0)
(E)	**Opinion on Usefulness of Mechanical Compression Devices**		
i	Mechanical compression devices may be useful in all situations, regardless of duration of transfer from scene to ambulance, or duration of transport.	Transfer: 17 Transport: 15	(85.0) (75.0)
ii	Provided that there is good quality CPR on the scene by first responders, a mechanical device may be brought in by a second tier.	19	(95.0)

Survey – Delphi Round 2

Microsoft Office
d 97 - 2003 Docun