CLINICAL UPDATE

09/01/2023

JRCALC Clinical Guideline Updates 1/2023

On Monday 9th January the JRCALC plus app will be updated with the attached amendments. The Trust has reviewed all these changes and will be implementing all of them without changes.

If any individuals have any questions, please contact your LOM and or Clinical lead.

New JRCALC Guidelines/medicines:

Guideline	Update
NEW guideline: Agitated patients	A new guideline for JRCALC. This will sit alongside the existing guidance for acute behavioural disturbance (ABD). JRCALC are also in the process of developing new guidance on delirium. Agitation can have multiple causes and the clinical management can be challenging. The focus should be on identifying and treating, or arranging to treat the underlying cause.

Updates, Corrections, and Additional Guidance to Existing JRCALC Guidelines:

Guideline/medicine	Update
Acute coronary syndrome	Full review and update of ACS. New section on health inequalities, women and racial differences. New wording added: *Undertake a risk benefit analysis regarding the most appropriate method of transferring the patient to the ambulance with the aim of limiting patient movement and walking to reduce stress on the myocardium.* Strengthened wording re. need to reduce on-scene time if possible. New wording added: *If facilities exist, transmit 12 lead ECG for expert review in cases of uncertainty about interpretation, or seek senior clinician support using ambulance services local pathways. Automated ECG interpretation is widely available and is a useful support tool.* *Some patients do not have 'classical' presentations (especially older people, and those with diabetes). This group have a high mortality due to delayed diagnosis and treatment, therefore paramedics should have a low threshold for recording a 12 lead ECG in unwell patients without chest pain.*

Guideline/medicine	Update
Acute coronary syndrome	*Patients who have transient ST elevation on the 12 lead ECG should not be discharged on scene. Seek senior clinical advice.* Pain management-*Administer sublingual glyceryl trinitrate (GTN) for patients with ongoing ischaemic discomfort unless the patient is hypotensive or otherwise contraindicated. A recent (2022) meta-analysis concluded that there is no statistically significant difference in the rate of adverse events when nitrates are administered to patients with right ventricular MI (RVMI) compared to other infarct regions. Adverse events in the included studies were minor and transient. While there are suggestions that morphine is associated with worse outcomes in STEMI patients, the evidence is of low quality, contradictory and thus uncertain. Morphine often delays the onset of action of P2Y12 inhibitors (e.g. ticagrelor, prasugrel).* *Morphine remains the analgesia of choice in moderate/severe pain associated with STEMI.* *IV paracetamol or Entonox are acceptable alternatives for moderate pain where morphine is contraindicated.*

Guideline/medicine	Update
Clopidogrel	Clopidogrel removed from JRCALC as part of ACS update. Follow local policies/guidelines for P2Y12 inhibitor antiplatelet agents (e.g. ticagrelor, prasugrel).

Guideline/medicine	Update
Changes to 'Trauma emergencies in adults-overview' and 'Spinal injury and spinal cord injury guidance' in relation to the trapped patient and extrication. Also additional wording added in relation to women and TXA administration.	Additional wording added around extrication, care during entrapment, self-extrication and time on scene. This is in relation to a Delphi study of rescue and clinical subject matter experts on the extrication of patients following a motor vehicle collision. https://pubmed.ncbi.nlm.nih.gov/35725580/ Also, a study around use of TXA in major trauma has concluded that administration of TXA to patients with bleeding trauma reduces mortality to a similar extent in women and men, but women are substantially less likely to be treated with TXA. This is now highlighted in the text and in the key points in 'Trauma emergencies in adults-overview' *https://pubmed.ncbi.nlm.nih.gov/35597623/*
Aspirin	This wording in additional information will be removed: *In suspected myocardial infarction a 300 milligram aspirin tablet should be given regardless of any previous aspirin taken that day.* It will be replaced with new wording to give better clarity, in the dosage section: *300mg must be given unless the patient has already had 300 mg for this episode. If the patient has had a smaller dose that day (less than 300mg) a dose of 300mg should be given.*

Guideline/medicine	Update
Buccal midazolam	Updates to title. Includes details of how to administer a buccal medicine. The repeat dose interval has been amended to 5-10 minutes.
Penthrox	Removal of dosage interval of 10 minutes. No minimum interval between doses.
Rectal Diazepam	Due to the 2.5mg rectal diazepam dose production being stopped, and in line with new APLS guidance the dosage for age one month and 3 months will change to 5mg.
Page for age and paediatric respiratory rates	For ages at birth and one month the respiratory rate changed to 40-60.
Further resources tab on the App	New resources to be added: Link to Health Education England e learning Link to 'Don't forget the Bubbles' website. Link to 'Mind the Gap: A handbook of clinical signs in Black and Brown skin' Additional wording added to the JRCALC disclaimer to say: *The Further Resources section contains links to websites owned and operated by third parties. The links are provided for your information, however JRCALC is not responsible for the content held within these sites.*