Doctors' experiences of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making: A meta-ethnography

Baker, Annalie; Pollard, Clare; Soundy, Andrew

courses, with deterioration at 6 months, mainly ventilation and defibrillation skills ($p < 0.05$).

Conclusions: The program showed the IHCA arrest real situation, improving skills of nursing staff in their care, noting where they require more emphasis and recycling, and improving recognition and care of more ill patients in unmonitored areas.

http://dx.doi.org/10.1016/j.resuscitation.2014.03.202

AP154

Death in the field post out-of-hospital cardiac arrest (OCHA): An analysis of one-year's ambulance data in Leinster, Ireland

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Purpose: Ambulance data are collected routinely in Ireland but are not always systematically analysed or reported. Cardiovascular disease is the leading cause of premature death in Ireland with an estimated 50% of these deaths occurring out of hospital. This study aimed to review existing ambulance data to generate information on the demographics of those who suffer these emergencies, circumstances of their collapse and outcome post out-of-hospital-cardiac arrest.

Methods and materials: A retrospective review was undertaken of all ambulance patient-care report forms (PRFS) for the year 2008. Data required for Utstein templates were extracted on all cardiac arrests cases. For data protection reasons, this study's outcome was status at transfer to hospital care. The setting is operational area for the Region's ambulance division, an area of 46,380 km^2, with population 1,499,705 (Central Statistics Office 2006) which covers three counties and has a population of 1,499,705 according to the 2006 National Census.

Results: A total of 32,128 PRFs were reviewed; of the 282 arrests, 214 were identified as treated adult cardiac arrest of presumed cardiac aetiology (0.7% of total calls). In 2008 30% ($n = 65/214$) of treated OHCA were declared dead in the field, 54.7% were transferred to hospital with ongoing CPR and 15% were alive with ROSC. There were subtle differences in predictors associated with being alive vs. being dead as outcome. When logistic regression controlled for age, distance from ambulance base, bystander-CPR and cardiac-arrest rhythm, female-gender and rural-location were independent predictors of being declared dead in the field. Those who had a witnessed arrest were half as likely to be dead.

Conclusion: This study provides valuable information for EMS planning, particularly in light of directives on response-time indicators from the Irish Health Information and Quality Authority and the challenges that these indicators present for pre-hospital care in low population-density rural areas.

http://dx.doi.org/10.1016/j.resuscitation.2014.03.203

AP155

Early survival from out-of-hospital cardiac arrest (OCHA) in Ireland: An analysis of one year's Ambulance Data in Leinster

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Purpose: Ambulance data are collected routinely in Ireland but are not always systematically analysed or reported. Cardiovascular disease is the leading cause of premature death in Ireland with an estimated 50% of these deaths occurring out of hospital. This study aimed to review existing ambulance data to generate information on the demographics of those who suffer these emergencies, circumstances of their collapse and predictors of and outcome post OCHA.

Methods and materials: A retrospective review was undertaken of all ambulance patient-care report forms (PRFS) filed for the year 2008. Data required for Utstein templates were extracted on all cardiac arrests cases. For data protection reasons, this study's outcome was status at transfer to hospital care.

Setting: The operational area for the Region's ambulance division, an area of 46,380 km^2, with population 1,499,705 (Central Statistics Office 2006) which covers three counties and has a population of 1,499,705 according to the 2006 National Census.

Results: A total of 32,128 PRFs were reviewed; of the 282 arrests, 214 were identified as adult cardiac (0.7% of total calls). In 2008 just 15% of OCHA treated cases were alive at transfer to hospital care When logistic regression analysis controlled for age, gender and distance from ambulance base of attending crew, only early CPR and a shockable cardiac-arrest rhythm were independent predictors of survival and were associated with a three and sevenfold increase in the odds of being alive respectively. A second model without a shockable-arrest rhythm as a predictor revealed that having a witnessed-arrest increased survival fourfold. Thus a witnessed arrest was crucial to being alive but this effect was mediated by its association with a shockable cardiac-arrest rhythm.

Conclusion: The usual Utstein factors predicted early-survival. This study supports the argument (Stiell et al., 1999) that predictors impact directly and indirectly on outcome after out-of-hospital cardiac arrest.

http://dx.doi.org/10.1016/j.resuscitation.2014.03.204

Ethics

AP156

Doctors' experiences of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making: A meta-ethnography

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Aims: The aim of this study is to use meta-ethnography to analyse and synthesise qualitative data that considers doctors experiences and attitudes towards DNACPR decision making.

Background: DNACPR decisions identify patients who would not benefit from having cardiopulmonary resuscitation attempted. With recent high profile media interest and published recommendations[1] there is a need for a greater understanding about doctors' attitudes towards DNACPR decisions, and the barriers which they perceive when making such decisions.

Methods: A comprehensive literature search was conducted including MEDLINE, EMBASE, PsychINFO, CINAHL, Cochrane library, PubMed, Web of Science and bibliographical reviews of retrieved studies (February 2002–2013). All retrieved articles were reviewed to identify published qualitative research focusing on doctor's experience/attitudes of DNACPR decision making in Adults. The original search identified 377 studies. After exclusions nine relevant studies were identified. Two researchers independently reviewed and critically appraised the studies. Key themes and concepts were extracted from each study. Techniques of meta-ethnography were followed to synthesise the findings.

Result: Four major themes were identified that highlight common issues and concerns experienced by doctors: ethical concerns, decision making, conflicts and communication. A line of argument synthesis produced a decision-dilemma model that describes the challenges faced in three distinct phases of DNACPR decision making: pre decision, making the decision and post decision.

Conclusions: Doctors experience a range of common concerns and issues which may affect the decision making process. DNACPR decisions are influenced by balancing conflicting clinical and ethical demands. This information is well placed to inform future training and policy to provide support for doctors when making DNACPR decisions.

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1. Findlay G, Shotton H, Kelly K, Mason M. Time to intervene? A review of patients who underwent cardiopulmonary resuscitation as a result of an in-hospital cardiorespiratory arrest. A report by the National Confidential Enquiry into Patient Outcome and Death, http://www.ncepod.org.uk/2012report1/downloads/CAP_fullreport.pdf.

http://dx.doi.org/10.1016/j.resuscitation.2014.03.205

AP157

"End of life" procedures and Advanced Health Care Directives in the Andalusian Health Emergency Agency (EPES). 2013 review

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Introduction: "All people aspire to live in dignity. Live in dignity is and should be considered as an aspiration for all human race. In Spain, the legal system is intended to simultaneously define and protect this aspiration. But death is part of life. Dying is the final act of the personal biography of every human being and can't be separated from that as something different. Therefore, the imperative of decent life also extends to death. A dignified life requires a dignified death". This is a part of the preamble of the Law 2/2010 of Rights and Interests of the Person in the Dying Process and from EPES we consider it very revealing for making progress and advancing in care in this field, as previous resuscitation ERC guides and related relevant documentation have pointed out.

Objectives:

1. Show how the current proceeding about the "Advanced Health Care Directives" (AHCD) at the "End of Life" was modified, in order to incorporate bioethical aspects that orient in end-of life decision making to CCUEs and EMS personnel.
2. Explain how this process was developed with the engagement of all the professionals from the Emergencies-Call-Centers (CCUEs) and the Emergencies Medical Services (EMS) personnel involved, towards properly and regularly assessed flows of information.

Method and material: Descriptive. Developments of the AHCD to the procedure "End of Life" and his application in EPES. The procedure was discussed and agreed on by the Ethics Committee EPES, submitted and approved by the general corporation and disseminated amongst professionals. It is indeed already part of our quality system and is incorporated into Salud Responde and CCUEs management of procedures through several triage telephonic guides and out-of-hospital ALS patient management. Doctors and nurses had been trained from early 2013 to act according to the lex artis in these types of situations. In the emergency health assistance provided by the SEM personnel, accurate patients were labelled with the V66.7 clinical code (ICD) and the nursing care provided recorded with the intervention Dying Care NIC 5260.

Conclusions: The change in the AHCD application procedures to the "End of Life" has become into 6 guides of telephonic triage to assist in decision making for cases of certain situations in palliative care when the end of life has to be nearly considered, and resuscitation efforts might be considered or not. The vision adopted needs further developing to enable emergency personnel in improving critical care in this situations, avoiding suffering, pain and ensuring the individual wills and needs are properly addressed, giving meaning to every single vital project.

Further reading

1. Ley 2/2010, de 8 de abril, de Derechos y Garantías de la Dignidad de la Persona en el Proceso de la Muerte.
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http://dx.doi.org/10.1016/j.resuscitation.2014.03.206

AP158

Ethical approaches of candidates participating ERC ALS provider courses in Turkey

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Purpose of the study: Ethical decisions on resuscitation may be affected by personal, international-regional, legal, religious, social and cultural factors. In this study we aimed to determine the ethical approaches of the candidates in ERC ALS provider courses that have been organized in Turkey.

Materials and methods: Candidates ($n = 121$) that have been participated ERC ALS provider courses in Turkey between June 2013 and January 2014 were included in the study. Study data were collected with a questionnaire (total 15 questions). The questions were prepared to determine the knowledge and opinions about ethical concepts and approaches. The survey study has been realized before the ethical lecture of ERC ALS course.

Results: The candidates participating the questionnaire were male in 46.4% and female in 53.6%; physician in 75% and other healthcare personnel in 25%. Religious beliefs were Moslem in 93.4%, atheist in 3.3%, Jewish in 1.6% and other in 1.7%. 88% of the participants know the meaning of DNR and working unit is effective on decision ($p = 0.024$). 51.3% believed that age is not a determining factor for DNR decision and 71.4% believed that CPR applied patients may be organ donor. 67% did not have information about legal aspects of DNR and did not believe autonomy.

Conclusion: Resuscitaion should be started fastly and efficiently, but inappropriate or "stop CPR" situations must be recognized. This study revealed lack of knowledge of ERC ALS provider course candidates and emphasized the requirement of