

protocol, for instance to allow administration to people accompanying patients during emergencies.

EP10

A SERVICE EVALUATION CALCULATING THE LENGTH OF RESUSCITATION BEFORE RETURN OF SPONTANEOUS CIRCULATION (ROSC) OR TERMINATION OF RESUSCITATION (TOR) BASED ON EXISTING TOR GUIDANCE IN SOUTH WEST ENGLAND

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Background Annually in South West England 3,500 people receive a resuscitation attempt following an out-of-hospital cardiac arrest (OHCA). Paramedics use Termination of Resuscitation (TOR) guidelines to identify patients no longer benefiting from further resuscitation. This facilitates a dignified death and enables resource deployment to other patients. Historically, TOR was only supported for patients who remained continuously asystolic for 20 mins, however, the impact this guidance had on total resuscitation duration was unknown.

Methods This retrospective registry-based evaluation reviewed adult OHCA cases between 1st April 2016 – 31st March 2022. OHCA witnessed by ambulance personnel were excluded along with cases containing missing time, demographic, or outcome data. Patients who re-arrested following return of spontaneous circulation (ROSC) were excluded. Resuscitation Duration (RD) was calculated as the time between the arrival of the first ambulance resource to either ROSC or TOR. Routinely collected 30-day survival data was included in the evaluation.

Results 13,092 cases were eligible for analysis. 9,392 patients received prehospital TOR (median RD 34.50mins) whilst 3,700 achieved ROSC (median RD 20.10 mins), 861 patients survived to 30-days (median RD 12.17 mins). A total of 7,989 patients presented with an initial rhythm of asystole, 6,701 of these patients had TOR (median RD 34.5 mins) whilst 1,288 achieved ROSC (median RD 23.33 mins), only 49 asystole patients survived to 30-days (0.6%). 24.0% of the sample (n=3,144) presented in a shockable rhythm, 1,517 of these patients had TOR (median RD 42.85 mins) whilst 22.5% (n=708) survived to 30-days (median RD 14.73 mins)

Conclusion Existing TOR guidance delivers resuscitation for greater than 30mins to most patients, regardless of initial presenting rhythm. Resuscitation attempts ending in TOR exceed the average duration needed to achieve ROSC for patient who survive to 30-days. This evaluation suggests that total resuscitation duration could be considered in future TOR guidance, irrespective of presenting or continuous arrhythmia.

EP11

WHAT IS A PRE-ALERT? EXPLORING AMBULANCE SERVICE PERSPECTIVES OF PRE-ALERTS AND THE PRE-ALERT PROCESS

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Background Pre-alert calls involve an ambulance clinician contacting an ED/hospital about a seriously ill patient prior to arrival and enables receiving EDs to prepare appropriate responses e.g. ensure appropriate staff/resources are in place to facilitate timely care on arrival. Approximately 1/10 English Emergency Department (ED) conveyances are pre-alerted.

There is trust-level variation around pre-alert guidance. This research aims to explore the pre-alert purpose and process from an ambulance perspective and identify sources and impacts of variation.

Methods We report qualitative findings from a mixed-method study (semi-structured interviews n=35 paramedics/EMTs/specialist paramedics at 3 ambulance services and observation of 109 pre-alerts at 5 EDs). Data collection occurred between August 2022-February 2023. Interview transcripts and observation notes were analysed thematically within NVivo.

Results Ambulance clinicians identified multiple pre-alert purposes, ranging from getting a different response from receiving EDs, obtaining ED advice about where to take the patient, giving a 'heads up' that a poorly patient was en-route and 'courtesy calls' to adhere to pre-alert protocols. Some pre-alert calls sought advice about borderline pre-alert cases.

Variation was identified throughout the pre-alert process, including variation in how EDs were informed about pre-alerts (by crew on scene/trauma desk/ambulance control); contact methods used (ambulance mobile phone/personal mobile/ambulance radio); handover formats (ATMIST/SBAR/personal preference/ED preference); ED instructions on where to take the patient (Resus/ED majors/check-in at front door/clinician review elsewhere).

Our interviews identified process variation can make pre-alerts more challenging for ambulance crews when operating out of their usual locality. Some ambulance clinicians favoured a separate advice line for borderline pre-alert cases.

Conclusion Pre-alert process variability was identified within and between ambulance services. Consultation with the study PPI group highlights a preference for more consistency and less variability in pre-alert practice and this was identified in our interviews with ambulance clinicians as a potential area for improvement.

EP12

CO-PRODUCING AN AMBULANCE TRUST NATIONAL FATIGUE RISK MANAGEMENT SYSTEM FOR IMPROVED STAFF AND PATIENT SAFETY (CATNAPS): CO-DESIGN AND KEY INFORMANT INTERVIEW FINDINGS

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Background Fatigue is a known operational, staff and patient safety risk for emergency services. A fatigue risk management system (FRMS), as is used in other safety-critical industries like aviation and rail, can help manage these risks but are rare in the NHS. A multidisciplinary team that includes experts by experience from patient and staff perspectives aims to develop and usability test a FRMS for the UK NHS ambulance sector.