

acceptance of citizen responders entering private appartements and safety for both first responders and patients.

**Method** Retrospective analysis of the data from the smart-phone-based dispatch system for citizen responder „KATRETTETTER' and prehospital outcome data from the Berlin EMS including all OHCA-alarms to which a citizen responder was alerted in the period from 28.09.2020 and 28.02.2021.

Results citizen responders were activated to suspected OHCA 4614 times, of these 2305 (=50%) were located in private apartments. Citizen responders arrived on scene at residential locations 1053 times (=45,7%) and prior to EMS in 628 cases (27,3%). There was a significant difference in confirmed OHCA and CPR-attempts between the residential setting (38,9%) and calls in public spaces (14,5%). In 11 cases (1%) citizen responders were not granted access to the private apartment. During the observation period there were no reports of any legal or ethical problems.

**Conclusion** Sending citizens responders to these calls is safe and even necessary, as most of the OHCA occurred in private apartments. Also the absolute number and the ratio of suspected to confirmed OHCA is higher in the residential setting than in public.

**Conflict of interest** None declared.

**Funding** None declared.

## Miscellaneous

### 344 PROGNOSTIC VALUE OF ON-SCENE ANALYTIC PARAMETERS FOR ORGAN VIABILITY IN DCD DONORS

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**Background** An increasing number of Spanish EMS have started Donation after Circulatory Death (DCD) protocols for not Recovery Of Spontaneous Circulation patients (ROSC) (Type IIa donor in the modified Maastricht Classification, Madrid 2011). The decision to proceed with the donation is taken according to established criteria by the transplant coordination and the organ implantation team.

**Method** Analytical observational: Population: Patients in DCD attended by an EMS with no ROSC who complies with criteria to be included in the DCD code (2009 – 2020) Exclusion: Missed in the system, non-clinical criteria excluded.

Independent variables: Epidemiological (age, sex) analytical parameters: (pH, lactate, glucose, BE, PCO<sub>2</sub>, bicarbonate). Variable result: Graft viability. Descriptive analysis: central and quantitative dispersion measures. Qualitative variables percentages. Inferential analysis: Student's T-distribution for quantitative variable, chi-squared for categorical variables. SPSS V17.

**Results** 136 deceased donors included.

Age: 45.89 (±9.56). Organs were viable in the 82.35% (112) of the cases. The 90.44% of the patients (123) were male.

Age: 46.7 (SD-8.5) viable, 41.7 (SD-12.6) non-viable,  $p=0.017$

Lactate: 6.93 (SD- 2.82) viable, 5.93 (SD-2.5) non- viable,  $p= 0.181$

COH3: 23.73 (SD-8.8) viable, 22.91 (SD-4.6) non – viable,  $p= 0.681$

pH: 7.11 (SD- 0.16) viable, 7.06 (SD-0.34) non – viable,  $p=0.374$

Glucose: 166.3 (SD- 83.9) viable, 141.3 (SD – 78.5) non – viable,  $p=0.243$

**Conclusion** The differential tendency towards more pathological values in parameters such as bicarbonate and pH when organs were non-viable for donation could be highly engaging. However, reaching significant statistics data has been unfeasible, most likely to the insufficient number of cases available for study. Consequently, adding more cases and other parameters turns necessary.

**Conflict of interest** None declared.

**Funding** None declared.

## Quality improvement and organization

### 345 THE USE OF COERCION IN THE AMBULANCE SERVICE – A QUALITATIVE STUDY OF A LARGE URBAN AMBULANCE SERVICE

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**Background** Voluntary and informed consent is a fundamental principle of healthcare provision. However, health care laws in some countries allow for exceptions from the consent requirement when patients are not competent to consent or pose a danger to themselves or others. In these cases, the use of coercion may be an alternative to voluntary health care. Ambulance personnel are confronted with patients who need healthcare but refuse it and/or refuse to cooperate. To what extent coercion is used by ambulance personnel in these situations or what constitutes coercion in a pre-hospital setting has not previously been explored. This study therefore examines (i) ambulance personnel's perceptions of coercion, (ii) their experience of the use of coercion, (iii) situations in which they have used coercion, and (iv) forms of coercion they have used.

**Method** We conducted focus group interviews with a group of ambulance personnel from a large Norwegian ambulance service. Digital recordings of the interviews were transcribed verbatim and the transcripts were analysed using Systemic Text Condensation.

**Results** Informants primarily interpreted and described coercion as the use of physical force. Other types of coercion as persuasion, pragmatic force, pharmacological coercion and securing during transport were described.

**Conclusion** The different methods of force/coercion are mainly used in situations where the ambulance personnel consider that healthcare is necessary but the patients refuses. The findings indicate that adherence to emergency law, a duty to help, the welfare of the patient and insecurity or fear promote the use of coercion among ambulance personnel. Insecurity and fear seem to be rooted in: 1) an experienced contradiction between the ambulance service's guidelines and the legislation, 2) fear of breaching guidelines and leaving patients behind because of lack of support from management, and 3) fear of charges of misconduct. The difficulty of applying the law in real-life situations and assessing competence is also a contributory factor.

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