Australasian Emergency Care 28 (2025) 294–299

Contents lists available at ScienceDirect

Australasian Emergency Care

journal homepage: www.elsevier.com/locate/auec

Research paper

Emergency ambulance care of families during death, dying, and bereavement: A document analysis of Australian and Aotearoa New Zealand clinical practice guidelines

Eillish Satchell [a,*], Merryn Gott [a], Madeleine Juhrmann [b,c,d,e], Bridget Dicker [f,g], Natalie Elizabeth Anderson [a,h]

[a] Te Ārai Palliative Care & End of Life Research Group, School of Nursing, The University of Auckland, Auckland, New Zealand
[b] Research Centre for Palliative Care, Death and Dying (RePaDD), College of Nursing and Health Science, Flinders University, Bedford Park, Australia
[c] Palliative Nexus, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne, Melbourne, Australia
[d] Improving Palliative, Aged and Chronic Care through Clinical Research and Translation (IMPACCT), Faculty of Health, University of Technology Sydney, Ultimo, Australia
[e] The Palliative Centre, HammondCare, Greenwich, Australia
[f] Auckland University of Technology, Auckland, New Zealand
[g] Hato Hone St John New Zealand, Auckland, New Zealand
[h] Adult Emergency Department, Te Toka Tumai, Te Whatu Ora, Private Bag 92024, Auckland Mail Centre, Auckland 1142, New Zealand

ARTICLE INFO

Keywords:
Family
Paramedicine
Bereavement
Death
Practice Guidelines

ABSTRACT

Background: Ambulance personnel play an important role in supporting families during death, dying, and bereavement. Evidence-based clinical practice guidelines are crucial for ensuring high-quality ambulance care. However, it is unknown what guidance currently informs care of bereaved families. This document analysis examines ambulance guidelines pertaining to family care in out-of-hospital death in Australia and Aotearoa New Zealand.

Methods: Clinical practice guidelines were sourced from all Australian and Aotearoa New Zealand ambulance services. Using qualitative document analysis, guidance addressing family care during death, dying, and bereavement was examined. Analysis was conducted using a customised coding framework informed by the Australian National Consensus Statement: Essential Elements for safe and high-quality end-of-life care.

Results: While most guidelines included essential elements of end-of-life care, there was significant heterogeneity in the scope, detail and nature of guidance. Care instructions varied between services, populations and clinical scenarios. Guidance pertaining to culturally safe care was limited.

Conclusions: Ambulance clinical guidance remains focused on technical skills during resuscitation, death, and dying. More guidance is needed to inform important elements of family care such as communication, family partnership, and cultural safety. Incorporating evidenced-based principles of end-of-life care presents an opportunity to improve ambulance support for bereaved families.

Introduction

Although historically positioned to save lives, emergency ambulance personnel are increasingly attending events where a death occurs [1,2]. These events can vary from unexpected deaths to palliative care situations. Family members are commonly present during out-of-hospital deaths, and providing family-centred care is a crucial aspect of quality end-of-life care [3]. Where the needs of bereaved family members remain unmet, there is an increased risk of psychological harm and prolonged grief [4]. In out-of-hospital deaths, emergency ambulance personnel may be the first and only healthcare professionals with whom family members interact. Recent studies have shown that emergency ambulance care in the event of a death can have a lasting impact on family experiences [5,6]. However, ambulance personnel often feel unequipped and poorly prepared to respond to the needs of bereaved families [7–9]. An additional factor known to affect bereavement care is

* Correspondence to: School of Nursing, The University of Auckland, Private Bag 92019, Auckland 1142, New Zealand.
E-mail address: eillish.satchell@auckland.ac.nz (E. Satchell).

https://doi.org/10.1016/j.auec.2025.06.004
Received 26 March 2025; Received in revised form 10 June 2025; Accepted 22 June 2025
Available online 26 June 2025

the emotional burden experienced by healthcare professionals [10]. Responding to situations where death occurs is reported to be stressful and can impact the wellbeing of ambulance personnel [11,12]. Studies have highlighted that education and resources around grief and death as well as access to post-event support, and debriefing are needed to support ambulance personnel's wellbeing [13,14]. It is, therefore, important to consider what guidance informs the care of ambulance personnel who experience patient death.

Globally, emergency ambulance practice is commonly guided by clinical practice guidelines (CPGs). CPGs are protocols outlining standards of care based on evidence-based practice across various clinical scenarios [15]. Evidence shows that the provision of established guidelines facilitates improvements in family bereavement care [16]. However, bereavement guidelines have been shown to vary significantly [17]. Across Australia and Aotearoa New Zealand, there are ten emergency ambulance services, most of which have individual CPGs [18]. Previous studies have explored the way in which CPGs provide paramedic guidance in palliative care situations [19], and identified the importance of family support in paramedic palliative care [20]. However, palliative care is only one aspect of death scenarios that paramedics will face. Family bereavement needs may be different in cases of unexpected deaths. Consequently, examining what bereavement guidance is given in relation to general paramedicine practice is crucial.

This qualitative document analysis identifies and critically examines ambulance CPGs from Australia and Aotearoa New Zealand, relating to family care in death, dying, and bereavement. Guidelines are compared to best practice principles in end-of-life care to identify potential improvements to support ambulance personnel and families in these often-challenging situations.

Method

Document analysis is a methodological approach that allows for the systematic examination and analysis of text [21]. . Guided by Schreier's Qualitative Content Analysis [22] we examined CPGs pertaining to family care in death, dying, and bereavement across all Australian and Aotearoa New Zealand ambulance services.

Study setting

Across Australia and Aotearoa New Zealand, there are ten autonomous emergency ambulance services that provide care based on geographical location (see Table 1). While there are differences between each organisation, in general, emergency ambulance services across these countries share similar characteristics, including transnational professional bodies [23]. Paramedics in Australia and Aotearoa New Zealand, work within increasingly professionally autonomous Anglo-American models [24]. In both countries, paramedics are registered health professionals. Workforces across services include volunteers, emergency medical technicians, and paramedics [23]. We have referred to all ambulance responders as emergency ambulance personnel in this study.

Table 1
Ambulance services in Australia and Aotearoa New Zealand.

Jurisdictional Ambulance Service	Region Servicing
ACT Ambulance Service	Australian Capital Territory
New South Wales Ambulance Service	New South Wales
St John Ambulance NT	Northern Territory
Queensland Ambulance Service	Queensland
South Australia Ambulance Service	South Australia
Ambulance Tasmania	Tasmania
Ambulance Victoria	Victoria
St John Ambulance WA	Western Australia
Hato Hone St John	Aotearoa New Zealand [excluding Wellington region]
Wellington Free Ambulance	Wellington Region

Inclusion criteria

Nine CPGs from all ten ambulance services were included (Aotearoa New Zealand ambulance services Hato Hone St John and Wellington Free Ambulance share one CPG). All guidelines pertaining to death, dying and bereavement were considered, including adjunct topics that may affect clinical care, such as voluntary assisted dying and organ donation. Only clinical practice guidelines were considered in this review, with other sources of ambulance personnel information, such as training material or other supplementary policies, being excluded. No limitations were set restricting definitions of family. Several ambulance services have differing guidelines for different levels of ambulance personnel's scope of practice. Guidelines for expanded scope of practice roles, such as extended care practitioners and intensive care paramedics, were included in CPG searching. Where there were differing guidelines by scope pertaining to family care, they were included in analysis.

Data collection

Clinical practice guidelines are publicly available information across Australian and Aotearoa New Zealand ambulance services. A three-step search strategy was developed to ensure systematic collection and searching of CPGs. This strategy was informed by a trial search in October 2024 of three randomly selected (through computer generation) CPGs. During the trial search, CPGs were manually searched for relevant material and compilation of keywords.

Step One: data collection from ambulance services

All ambulance services were contacted in November 2024 with a request to share guidelines relating to family care in death, dying, and bereavement. This allowed for the most current guidance and any additional available guidance to be collected. Four services provided CPGs to us directly, and another three directed us to their website for access to published guidelines. Where no response from services was provided, publicly available CPGs were considered. Data extraction of CPGs from ambulance service websites was completed in January 2025.

Step Two: keyword searching

Clinical practice guidelines were searched using the following keywords to identify relevant information*: Family, Death, Dying, Bereavement, Resuscitation, Termination, and Palliative.* Keyword searching was limited by CPG format. Boolean operators could not be used as many CPGS were documents, only allowing for word searching. Additionally, many digital CPG platforms only allowed for word searching of CPG titles rather than the full text.

Step Three: hand title screening of entire CPGs for relevant information

Author ES hand-searched all CPGs conducting title screening for relevancy. Relevancy was not limited to keywords but rather potential for the topic to contain information relating to death, dying and bereavement.

Coding frame development

The initial coding frame was developed based on the Australian Commission on Safety and Quality in Health Care (25) National Consensus Statement: Essential elements for safe and high-quality end-of-life care (hereafter EOLC consensus statement). This consensus statement provides nine overarching principles to guide patient and family care during death, dying and bereavement. The EOLC consensus statement was selected from a range of frameworks for its relevance to Australasian healthcare professionals working across a variety of settings. As these principles are broadly relevant to end-of-life care and not

specifically for a paramedicine context, researchers modified the coding framework to be more applicable to paramedicine based on previous literature exploring paramedicine family care in the event of death [5]. A trial coding of three ambulance service CPGs then informed initial changes to the framework. The final coding framework was collaboratively optimised and agreed by all authors (see Table 2).

Analysis

Extracted CPGs were uploaded to analysis software programme NVIVO for deductive coding of CPGs to the coding framework. Coding was primarily undertaken by ES with support from NA. Descriptive statistics were then used to map the frequency of coding across the CPGs and shared meaning between codes examined were examined.

Results

Relevant CPGs were included from all eight Australian ambulance services [26–33] and one shared guideline from Aotearoa New Zealand [34]; findings are displayed in Table 3.

The majority of ambulance services made mention of the importance of recognising and responding to the needs of the family during death, dying, and bereavement. However, the level of detail between guidelines varied. Generic, brief instructions such as "*offer family support*" were often given, without examples of what that support might include.

Table 2
Coding framework.

Coding dimension	Code description
Code 1: Responsiveness to family needs and wishes during death, dying and bereavement	Family should be included in emergency ambulance care during death, dying, and bereavement. Family needs and wishes should be considered.
Code 2: Provide family with information they can understand	Family should be provided with information they can understand during death, dying and bereavement.
Code 3: Consider cultural and spiritual needs	Meeting the cultural and spiritual needs of people and their families during death, dying, and bereavement is as important as meeting their physical needs.
Code 4: Liaison between service providers and family	Ambulance personnel often engage with emergency services, healthcare professionals, and community services. Involvement of interdisciplinary services can impact family experiences. Family should be informed and involved in inter-professional decision-making.
Code 5: Recognising advance treatment decisions	Due to the emergent nature of ambulance care, the patient is often unable to make decisions. Emergency ambulance personnel should be aware that decisions regarding treatment may be made in advance. Care should follow advance care plans or consult enduring power of attorneys where applicable. While families often do not hold legal decision-making power, perspectives from the family can provide insight into the patient's wishes.
Code 6: Not be burdensome or harmful	Emergency ambulance personnel's actions during resuscitation and in the event of death should not be unnecessarily burdensome or harmful. Treatments, investigations, and transfers that will not offer reasonable hope or benefit can be harmful to the patient and their family.
Code 7: Support for emergency ambulance personnel	Responding to death, dying, and bereavement scenarios can impact the wellbeing of emergency ambulance personnel. Guidelines should consider the wellbeing of responders.

Table 3
Emergency ambulance clinical guidance for death, dying and bereavement.

Principles of essential elements for end-of-life care	CPGs contain information relating to end-of-life principles	CPGs do not contain current information relating to end-of-life principles
Responsiveness to family needs and wishes	8	1
Provide information that families can understand	7	2
Consider cultural and spiritual needs	3	6
Liaison between service providers and family	5	4
Recognising advance treatment decisions	8	1
Not be burdensome or harmful	9	0
Support for emergency ambulance personnel	6	3

Where more detailed guidance regarding family support was provided, it instructed on care for the deceased's body in accordance with family wishes, recognising grief reactions and acting compassionately to the family.

Clinical guidance differed depending on the nature of a death. Pregnancy loss, palliative care, and deaths concerning paediatric populations involved more bereavement guidance than other clinical scenarios. Some services referred to different processes for paediatric death. For example, specific bereavement services were identified for child loss, additional guidance on family presence during resuscitation of a child and in one guideline, mandatory transfer to emergency departments to allow for bereavement care of the family. Guidelines for palliative care also included significantly more references to supporting families. It was common for palliative care guidelines to differ from the management of other death scenarios, particularly regarding the inclusion of non-technical skills essential for providing family care. Only one service provided differing guidelines pertaining to family care during death, dying, and bereavement for an extended care paramedic scope of practice.

Provide family with information they can understand

Guidance on communication with family was provided by seven of the nine services. Communication guidance primarily focused on informing family when a death had occurred. There was limited guidance reporting on family communication while resuscitation was ongoing, with only two services including communication with family as part of the resuscitation guidelines. Two services referenced evidence-based communication strategies such as GRIEV_ING and SPIKES guidelines for breaking bad news. Another service incorporated elements of therapeutic communication strategies as demonstrated in the following extract, 'Be *compassionate in your communication and use plain language; say that the patient is dead or has died. Allow whānau [family] to express grief. Ask whānau if they have any questions.*' [34] Two ambulance services also included multi-modal communication guidance providing families with resources in palliative care and out-of-hospital death.

Consider cultural and spiritual needs

Guidance surrounding culturally safe care for bereaved families was low across services, with only three services providing guidance. Clinical guidance informed ambulance personnel about common cultural beliefs held by different groups within their populations, namely Māori in Aotearoa New Zealand, and Aboriginal and Torres Strait Islanders in Australia. One service also provided further guidance on traditional Sikh, Hindu, and Muslim beliefs during death. All three services

referenced cultural diversity, adding that ambulance personnel must respond to the individual needs of families.

Liaison between service providers and family

In out-of-hospital death, ambulance personnel liaise with several services. However, families were not always included in interservice collaboration. CPGs only scored 'yes' if they referred to informing and including family in interservice collaboration. Unexpected deaths attended by emergency ambulance personnel commonly required police attendance, to ensure coronial procedures are initiated. While all CPGs included guidance for reportable deaths, only four services instructed on including family in interservice involvement. The most common interservice liaison involving family was with funeral directors. Several services encouraged ambulance personnel to offer support to the families in arranging funeral directors. This is shown in Northern Territory CPGs where collaborating with family to arrange funeral directors is highlighted as a practical and supportive action.

"Family members/ carers may also require assistance with contacting the funeral director, the patient's palliative care healthcare provider / general practitioner or even contact other family members who may be interstate or overseas. Providing assistance where practical and within operational demand, can go a long way in assisting the family in early grief and is often remembered forever by the family/ carers." [32]

Recognising advance treatment decisions

Recognising advance care directives in decisions to withhold resuscitation was included in eight services' CPGs. Most services required written directives to be sighted by ambulance personnel; however, four accepted verbal conveyance of advance directives by family. Seven services included palliative care guidelines outlining goals at the end of life for palliative patients and their families. Five services also had guidance on voluntary assistance dying, recognising that attempting resuscitation where voluntary assisted dying had occurred would not be in the best wishes of the patient or family.

Not be burdensome or harmful

All emergency ambulance services provided guidance on treatment and transfer decisions where patient and family benefits may be non-existent. Recognition of treatment burden vs benefit was commonly discussed in palliative care guidelines. Many services included shared decision-making with family in palliative care regarding treatment goals and patient transport, recognising that unnecessary interventions can be harmful and not align with patient and family wishes. No services included family members in resuscitating decision-making outside of palliative scenarios.

Guidance on the benefit-to-harm ratio in resuscitation decision-making varied. One service's guidelines centred on acting in the best interest of the patient and included factors indicating non-beneficial resuscitation. Two services referenced the frailty score as an indicator to withhold resuscitation, acknowledging that patients with high frailty scores (7−9) were unlikely to have favourable resuscitation outcomes. Other services advised withholding resuscitation in instances of life extinction and advised termination after certain time periods, which varied widely from 10 to 45 minutes between guidelines. One organisation instructed personnel not to terminate resuscitation in paediatric cases, regardless of futility or family wishes, to facilitate transfer to hospital for further resuscitation and family support.

Support for emergency ambulance personnel

Support for ambulance personnel was considered only if it related to critical events, excluding general wellbeing support. Six services acknowledged the impact of responding to death on emergency ambulance personnel and provided information on accessing support. Some services also mentioned debriefing after resuscitation, though this was typically clinical and lacked psychological elements, excluding it from this code. One service provided specific guidelines for personnel support in the event of a paediatric death, where support services are automatically triggered to contact the responders involved.

Discussion

Guidance for family care in death, dying, and bereavement varies greatly between ambulance services in Australia and Aotearoa New Zealand. While most CPGs mention family care, guidance is often non-specific and does not provide enough information to effectively guide evidenced based practice. Evidence underpinning best practice for family bereavement care highlights the importance of non-technical skills that prioritise communication and empathy [25]. However, CPGs continue to prioritise guidance of technical skills during resuscitation, death, and dying, often excluding guidance of family care. Juhrmann et al [19]. have previously discussed the challenges of conveying non-technical skills in protocol-driven guidelines, which may explain their limited presence. However, studies show that ambulance personnel require more support and guidance with non-technical skills during death, underscoring their importance in CPGs despite reporting difficulties [12].

Findings showed variation in family care guidance between services and clinical scenarios. While some services included high levels of guidance, others largely omitted families. For instance, deaths involving paediatric, palliative care, or pregnancy loss had more discussion of family needs and examples of evidence-based bereavement care than other clinical events, such as adult resuscitation. Care of family guidelines also varied by timeframe, with few CPGs considering family needs during resuscitation compared to after death. However, research shows that care of family during resuscitation can significantly impact family experience, meaning it is important that care of families is also considered during resuscitation [35]. Separating family care instructions by scenario or timeframe may limit ambulance personnel's access to evidence-based guidance depending on the clinical scenario. A potential strategy to improve guideline access for ambulance personnel is a combined section on family care during resuscitation, death, and bereavement, which may focus guidance to be responsive to family needs rather than based on the clinical circumstances of each death. Streamlining family care guidance using evidence such as the end-of-life consensus statement may also provide an opportunity for more standardised guidance nationally. This sentiment is echoed by international palliative care experts in a recent Delphi study, where a strong consensus was achieved that developing national guidelines are integral to the further development of evidence-based bereavement care [36].

Cultural safety prioritises individual and organisational reflexivity of power, privilege and biases, which are essential for reducing health inequities [37]. A key finding of this study was the limited reporting of cultural safety during death, dying, and bereavement care, which is concerning given the well-documented global inequities in Indigenous health and accessibility to culturally safe care [38,39]. The provision of culturally safe care is especially pertinent to emergency ambulance services in Australia and Aotearoa New Zealand, as both countries have Indigenous populations with unique cultural needs during death and dying [40,41]. Current ambulance guidance emphasises *cultural competence* rather than *cultural safety* by instructing care delivery to align with the common cultural beliefs of different populations [42]. While cultural competency is associated with increased patient satisfaction, simply holding knowledge about differing cultural beliefs is not synonymous with culturally safe care and can lead to cultural essentialism [43,44]. To reduce health inequities, it is essential that guidance for family care in death, dying, and bereavement include discussion of cultural safety alongside cultural competency [45]. Translating cultural safety from theory to practice is challenging [46]. However, as

ambulance personnel must respond to individual patient and family needs, future guidance should aspire to address the cultural safety gap evident in current guidance and paramedicine research [47].

A prominent variation in organisational guidance relates to decision-making in withholding and terminating resuscitation. Many services have prescriptive resuscitation guidelines; however, futile resuscitation is resource-intensive [48], offers no benefit to patients and can negatively affect families [49,50]. Current guidance largely excludes family from resuscitation decision-making unless they have legal guardianship. However, research into family experiences in out-of-hospital resuscitation highlights that families want to be informed and involved in shared resuscitation decision-making [5]. Families are well-positioned to provide medical information and advocate for their family members' wishes [49,51], indicating that their input may be valuable regardless of legal standing. Excluding family members input during resuscitation decision making can lead to unwanted treatment and transport [52] and leaves family feeling ignored [53]. Shared decision making during end-of-life care is established as a key element in patient and family-centred care in other settings such as intensive care units and palliative care [25,54]. However, applying shared decision making to an out-of-hospital context is complex. Several studies have explored barriers ambulance personnel encounter in involving family members in resuscitation decision-making, including accessing advance directives, time, varying views of family as proxy decision members, conflicting family and personnel perspectives, and fear of litigation [55,56]. Given these challenges, more research may be needed exploring how shared-decision making could be included in care guidelines to promote partnership between ambulance personnel and family members while addressing known ambulance barriers.

It is important to acknowledge that care during death, dying, and bereavement is a rapidly evolving field within paramedicine. As the scope of paramedicine continues to expand and diversify to include new roles, such as palliative care, it is crucial that the supporting evidence evolves accordingly. This article, therefore, provides a timely review of current updates that may help inform future family care during death, dying and bereavement.

Strengths and limitations

To our knowledge, this is the first study to evaluate emergency ambulance guidance of family care during death, dying, and bereavement. Limitations of data collection may have affected our ability to gather all clinical practice guidelines relating to family care. To increase search sensitivity, we employed a three-step search strategy, which included contacting organisations for CPGS directly. High response from organisations providing CPGs or directing us to publicly CPGs was a strength of data collection. Furthermore, as our analysis was limited to clinical practice guidelines, it may not encompass all materials that inform ambulance personnel's care of families during death, dying, and bereavement. As CPGs frequently update, information from ambulance services only reflects current guidance at the time of data extraction.

Conclusion

This document analysis highlights the significant variations in clinical practice guidance relating to the care of the family during death, dying and bereavement across Australia and Aotearoa New Zealand ambulance services. While many CPGs acknowledge that families require support in the event of a death, current guidance is brief and non-specific. Streamlining of guidelines to be more reflective of end-of-life care principles provides an opportunity to improve family care. Additionally, this study reveals a gap in culturally safe care during death and dying and highlights the necessity for guidelines that incorporate cultural safety principles. As the field of paramedicine evolves, it is imperative that CPGs are regularly updated to reflect best practices and address the diverse needs of families experiencing out-of-hospital deaths.

Ethics approval and consent to participate

As this is a review of existing research no formal ethics approval was required.

Author Contribution Statement

All authors have made substantial contributions to the conception, design and undertaking of the review, drafting and revising of the manuscript and final approval of the submitted version.

Funding

This research was undertaken as part of a Māori Health Clinical Training Fellowship funded by the Health Research Council of New Zealand (Grant No. 23/125/A). The funder had no role in the review's design and conduct or the manuscript's preparation.

Declaration of Competing Interest

The authors declare no competing interests.

References

1 Breyre A, Crowe RP, Fernandez AR, Jabr A, Myers JB, Kupas DF. Emergency medical services clinicians in the United States are increasingly exposed to death. J Am Coll Emerg Physicians Open 2023;4(1).
2 Hooper M, Rehn M. Beyond life extension– is it time for 'emergency last aid' training? Scand J Trauma Resusc Emerg Med 2025;33(1).
3 Pfaff K, Markaki A. Compassionate collaborative care: an integrative review of quality indicators in end-of-life care. BMC Palliat Care 2017;16(1).
4 Oechsle K. Current advances in palliative & hospice care: problems and needs of relatives and family caregivers during palliative and hospice care—an overview of current literature. Med Sci 2019;7(3):43.
5 Satchell E, Carey M, Dicker B, Drake H, Gott M, Moeke-Maxwell T, et al. Family & bystander experiences of emergency ambulance services care: a scoping review. BMC Emerg Med 2023;23(1):68.
6 Carlsson N, Alvariza A, Axelsson L, Bremer A, Årestedt K. Grief reactions in relation to professional and social support among family members of persons who died from sudden cardiac arrest: a longitudinal survey study. Resusc 2022;12:100318.
7 Anderson NE, Slark J, Gott M. When resuscitation doesn't work: A qualitative study examining ambulance personnel preparation and support for termination of resuscitation and patient death. Int Emerg Nurs 2020;49:100827.
8 Somers A. Are paramedic graduates effectively prepared for death? A scoping review. J Paramed Pract 2021;13(10):408–13.
9 Anderson NE, Slark J, Faasse K, Gott M. Paramedic student confidence, concerns, learning and experience with resuscitation decision-making and patient death: a pilot survey. Austral Emerg Care 2019;22(3):156–61.
10 Funk LM, Peters S, Roger KS. The emotional labor of personal grief in palliative care: balancing caring and professional identities. Qual Health Res 2017;27(14):2211–21.
11 Avraham N, Goldblatt H, Yafe E. Paramedics' experiences and coping strategies when encountering critical incidents. Qual Health Res 2014;24(2):194–208.
12 Myall M, Rowsell A, Lund S, Turnbull J, Arber M, Crouch R, et al. Death and dying in prehospital care: what are the experiences and issues for prehospital practitioners, families and bystanders? A scoping review. BMJ Open 2020;10(9):e036925.
13 Brown N. Sudden death: a pre-hospital perspective. In: Scott T, editor. Sudden Death: Intervention Skills for the Emergency Services. Cham: Springer International Publishing; 2020. p. 7–17.
14 Risson H, Beovich B, Bowles K-A. Paramedic interactions with significant others during and after resuscitation and death of a patient. Austral Emerg Care 2023;26(2):113–8.
15 Steinberg E, Greenfield S, Wolman DM, Mancher M, Graham R. Clinical practice guidelines we can trust. Natl Acad Press 2011.
16 Hudson P, Remedios C, Zordan R, Thomas K, Clifton D, Crewdson M, et al. Guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients. J Palliat Med 2012;15(6):696–702.
17 Kent K, Jessup B, Marsh P, Barnett T, Ball M. A systematic review and quality appraisal of bereavement care practice guidelines. J Eval Clin Pract 2020;26(3):852–62.
18 Wilkinson-Stokes M, Maria S, Colbeck M. A comparison of Australasian jurisdictional ambulance services' clinical practice guidelines series: an introduction. Australas J Paramed 2021;18:1–5.
19 Juhrmann ML, Anderson NE, Boughey M, McConnell DS, Bailey P, Parker LE, et al. Palliative paramedicine: comparing clinical practice through guideline quality appraisal and qualitative content analysis. Palliat Med 2022;36(8):1228–41.

20 Juhrmann ML, Vandersman P, Butow PN, Clayton JM. Paramedics delivering palliative and end-of-life care in community-based settings: a systematic integrative review with thematic synthesis. Palliat Med 2022;36(3):405–21.
21 Morgan H. Conducting a qualitative document analysis. Qual Rep 2022;27(1).
22 Schreier M. Qualitative Content Analysis. In: Uwe F, editor. The SAGE Handbook of Qualitative Data Analysis. London, England: SAGE Publications Ltd; 2014. p. 170–83.
23 O'Meara P, Duthie S. Paramedicine in Australia and New Zealand: a comparative overview. Aust J Rural Health 2018;26(5):363–8.
24 Makrides T, Ross L, Gosling C, Acker J, O'Meara P. Defining two novel sub models of the Anglo-American paramedic system: a Delphi study. Austral Emerg Care 2022;25(3):229–34.
25 Australian Commission on Safety and Quality in Health Care. Essential elements for safe and high-quality end-of-life care National Consensus Statement. 2023.
26 ACT Emergency Service Agency. Clinical management guidelines 2024 [Available from: ⟨https://cmg.ambulance.act.gov.au/tabs/guidelines⟩.
27 Ambulance Tasmania. Ambulance Tasmania clinical practice guidelines (CPG) 2024 [Available from: ⟨https://cpg.ambulance.tas.gov.au/tabs/guidelines⟩.
28 Ambulance Victoria. Clinical practice guidelines 2024 [Available from: ⟨https://www.ambulance.vic.gov.au/paramedics/clinical-practice-guidelines/⟩.
29 New South Wales Ambulance. Guidelines 2024 [Available from: ⟨https://cpg.ambulance.nsw.gov.au/tabs/guidelines⟩.
30 Queensland Ambulance Service. CPG: Clinical practice guidelines 2024 [Available from: ⟨https://www.ambulance.qld.gov.au/clinical/cpm/guidelines⟩.
31 South Australia Ambulance Service. SA ambulance CPG 2024 [Available from: ⟨https://www.clinical.saambulance.sa.gov.au/tabs/home⟩.
32 St John Ambulance Australia (NT) Inc. Clinical practice manual version 1.5 2024 [Available from: ⟨https://stjohnnt.org.au/img/documents/ambulance/St%20John%20Ambulance%20NT_Clinical%20Practice%20Manual_1.5_Final.pdf⟩.
33 St John Western Australia. Clinical practice guidelines 2024 [Available from: ⟨https://clinical.stjohnwa.com.au/clinical-practice-guidelines⟩.
34 Hato Hone St John. Emergency ambulance service CPGs 2024 [Available from: ⟨https://cpg.stjohn.org.nz/tabs/guidelines⟩.
35 Powers K, Duncan JM. K. Family support person role during resuscitation: a qualitative exploration. J Clin Nurs 2023;32(3-4):409–21.
36 Keegan O, Murphy I, Benkel I, Limonero JT, Relf M, Guldin M-B. Using the Delphi technique to achieve consensus on bereavement care in palliative care in Europe: an EAPC White Paper. Palliat Med 2021;35(10):1908–22.
37 Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, Paine S-J, et al. Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. Int J Equity Health 2019;18(1).
38 Kirmayer LJ, Brass G. Addressing global health disparities among Indigenous peoples. Lancet 2016;388(10040):105–6.
39 Espiner E, Paine S-J, Weston M, Curtis E. Barriers and facilitators for Maori in accessing hospital services in Aotearoa New Zealand. NZ Med J 2021;134(1546):47–58.
40 Moeke-Maxwell T., Mason K., Toohey F., Wharemate R., Gott M.He taonga tuku iho: Indigenous end of life and death care customs of New Zealand Māori. Death Across Cultures: Springer International Publishing; 2019. p. 295-316..
41 McGrath P. Aboriginal cultural practices on caring for the deceased person: findings and recommendations. Int J Palliat Nurs 2007;13(9):418–25.
42 Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: a systematic review of the literature. Health Soc Care Community 2016;24(6):e117–30.
43 Henderson S, Horne M, Hills R, Kendall E. Cultural competence in healthcare in the community: a concept analysis. Health Soc Care Community 2018;26(4):590–603.
44 Livingston G, Grant J, Sengstock B. Paramedics' understandings and perceptions of cultural safety and the provision of culturally safe care. BMC Health Serv Res 2025;25(1).
45 Curtis E, Loring B, Jones R, Tipene-Leach D, Walker C, Paine S-J, et al. Refining the definitions of cultural safety, cultural competency and Indigenous health: lessons from Aotearoa New Zealand. Int J Equity Health 2025;24(1):130.
46 Wilson L, Wilkinson A, Tikao K. Health professional perspectives on translation of cultural safety concepts into practice: a scoping study. Front Rehabil Sci 2022;3.
47 Satchell E, Anderson N, Gott M. Paramedicine research with family and bystanders: a methodological review. Paramedicine 2024:27536386241255387. 0(0).
48 Smyth MA, Gunson I, Coppola A, Johnson S, Greif R, Lauridsen KG, et al. Termination of resuscitation rules and survival among patients with out-of-hospital cardiac arrest. JAMA Netw Open 2024;7(7):e2420040.
49 Huxley C, Reeves E, Kearney J, Gardiner G, Eli K, Fothergill R, et al. Relatives' experiences of unsuccessful out-of-hospital cardiopulmonary resuscitation attempts: a qualitative analysis. BMC Emerg Med 2024;24(1).
50 Bremer A, Dahlberg K, Sandman L. Experiencing out-of-hospital cardiac arrest: significant others' lifeworld perspective. Qual Health Res 2009;19(10):1407–20.
51 De Stefano C, Domitille N, Jabre P, Azoulay E, Kentish-Barnes N, Lapostolle F, et al. Family presence during resuscitation: a qualitative analysis from a national multicenter randomized clinical trial. PLOS One 2016;11(6).
52 Edwardsen EA, Chiumento S, Davis E. Family perspective of medical care and grief support after field termination by emergency medical services personnel: a preliminary report. Prehosp Emerg Care 2002;6(4):440–4.
53 Weslien M, Nilstun T, Lundqvist A, Fridlund B. When the unreal becomes real: family members' experiences of cardiac arrest. Nurs Crit Care 2005;10(1):15–22.
54 Kryworuchko J, Hill E, Murray MA, Stacey D, Fergusson DA. Interventions for shared decision-making about life support in the intensive care unit: a systematic review. World Evid Based Nurs 2013;10(1):3–16.
55 Milling L, Kjær J, Binderup LG, De Muckadell CS, Havshøj U, Christensen HC, et al. Non-medical factors in prehospital resuscitation decision-making: a mixed-methods systematic review. Scand J Trauma Resusc Emerg Med 2022;30(1).
56 Feeney R, Willmott L, White B. Legal issues in end-of-life care for paramedics: a scoping review. J Law Med 2025;31(4):721–42.