

Highlights from this issue

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Mary Dawood, *Editor*

Would your department pass the family and friends test?

From April 2013, patients are being asked whether they would recommend hospital wards and emergency departments (EDs) to their friends and family if they needed similar care or treatment. Trusts are expected to collect qualitative feedback as well as ask the single 'would you recommend?' question. First impressions are lasting, thus the friends and family test (FFT) intensifies the pressure to ensure the patients first and ongoing impression of the service is recommendable to family and friends. Perhaps more importantly we need to understand why patients would not recommend our services. It is timely then to read the paper by Giacometti *et al* which describes and analyses interventions in the ED of an Italian hospital aimed at humanising the patient care pathway. Unsurprisingly patient satisfaction rose in those who attended the department following the interventions. Specifically what patients appreciated was greater comfort in the waiting room and greater privacy during Triage. It is clear from this study and previous studies that what matters to patients is the touch of humanity. If there is truth in the adage 'what gets measured gets managed' we should use this opportunity to get what we want and need for our departments.

Leadership in the ED

Good leadership skills are essential in emergency physicians to ensure patient safety and effective running of the department but traditionally assessment of non technical skills in trainees has been an arbitrary process. I was therefore very interested to read Flowerdew and colleagues' observational study evaluating a new tool to assess emergency physician's non technical skills. For those with the responsibility for assessing our future Consultants I would urge you to read this paper.

'To transfer or not to transfer'? It's not the only question

Inter hospital transfers of critically ill patients are fraught with risk and call for a multidisciplinary collaborative approach to minimise these risks. Vascular surgery, like stroke and trauma is increasingly being reconfigured in specialised centres to concentrate expertise and improve outcomes for seriously ill patients, particularly those presenting with ruptured abdominal aortic aneurysms. Initial management of these patients presents a challenge for the clinician in resuscitation but also a dilemma on the advisability of

transferring such patients out to a specialist vascular centre. In the UK and elsewhere in the developed world there are no guidelines to support the clinician dealing with such situations but most of us will be all too familiar with the difficulties that can arise in trying to agree the management plan and a shared goal. Hinchcliffe and colleagues in their Delphi study found broad agreement about eligibility for transfer but disagreement about management before and during, transfer. This paper will resonate with many of us who regularly manage the transfer of sick patients, read on to get the bigger picture...

Alcohol: signs of improvement

Excessive consumption of alcohol is a major public health and social issue and a preventable cause of premature mortality. Alcohol-related attendances in EDs are in many cases preventable yet prospective studies have repeatedly shown that significant numbers of adults and increasingly children attend EDs in the UK as a direct result of excessive alcohol consumption. Patients presenting with such conditions are high risk, dependent, and require disproportionate staff input which can significantly hinder the ability of the clinical team to deliver equitable care to other patients.

It is therefore somewhat reassuring to read The 2nd National ED survey of Alcohol Identification and Intervention comparing the results with a previous survey in 2007. Patton's cross sectional survey of 187 EDs in England found significant increases ($p < 0.001$) in the proportion of departments routinely screening for alcohol problems. More departments also have access to alcohol health workers or clinical nurse specialists. Is your department one of the 187 screening for alcohol?

Reducing inappropriate ED attendances

Rising attendance rates in EDs is a problem in many countries with overcrowding causing increasing concern. Reducing emergency attendances and re directing patients is essential not only because of the high and rising costs of emergency attendances compared with other forms of care but also because the ED is not always the right place to manage many of the presenting conditions.

Gareth Patton's retrospective review of ambulance attendances to a Scottish ED found that 30–32% of ambulance attendances were found to be attending 'inappropriately' in as much as 74–80% of these could have been managed in primary care. He concludes that reducing inappropriate ambulance attendance could reduce the

departmental patient load by 11%. This is not surprising to any of us working in the ED but it is a salutary message that those managing the roll out of NHS111 should take on board.

Where emergency medicine is not a specialty

From a different standpoint Bjornsen *et al* also reviewed retrospective data in their Norwegian ED where attendances have risen by 44% over the last decade. Interestingly Emergency Medicine is not a specialty in Norway, patients may be referred to the ED from urgent care or by the GP who is considered the 'gatekeeper' of the Norwegian Health Care system where the ED accounts for more than 60% of hospital admissions. Physicians seeing patients in the ED are usually drawn from different specialties as required. The authors state the need for change in their healthcare system in response to these increasing volumes but also identify the need and opportunity to establish Emergency Medicine as a specialty in its own right in line with other developed countries.

Accuracy in paediatric pre-hospital triage tools

Fortunately major trauma affecting children is small and infrequent but this poses challenges in organising paediatric major trauma services for severely injured children. The UK has fewer paediatric specialists/surgeons than most western economies which means that paediatric networks will have to cover larger geographical regions and severely injured children may be transferred greater distances than adults. Accuracy in pre hospital triage is therefore key to ensuring that highly specialist resources are used appropriately and children are not under or over triaged to these specialist centers'. Cheung *et al* investigated the performance characteristics of pre-hospital triage tools to identify seriously injured children, their main outcome measure being the functionality of each tool in terms of their under or over triaging features. Their findings will be of concern to paediatric clinicians and those involved in the organisation of paediatric trauma services. None of the pre hospital triage tools currently used or being developed in England meet recommended criteria for over and under triage which begs the question: are we providing the most appropriate care for our injured children? What do we need to do to improve in this area of trauma care?

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