Highlights from this issue

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Higher bed occupancy: Does it mean more deaths

In the UK we have heard a great deal about the 'weekend effect' the supposed increase immortality associated with weekend admissions. The size and reasons for that effect are hotly debated and in the emergency department we are used to seven day working, but what of the effect of crowding and bed occupancy? This month Boden *et al* show an association between bed occupancy and mortality. This is a paper you must read for yourself, as it's quite likely to be spun by those with vested interests in this political hot potato.

Are junior ED placements stressful?

The working conditions of junior doctors in the UK are currently the focus of much political debate. Proposed changes to the national contract have spotlighted concerns about the working conditions and stressors on our junior colleagues. Mason *et al* studied the well being, confidence and self reported confidence of junior doctors (PGY2) working in UK emergency departments. ED placements are often quoted as being the most stressful and this study confirms this, albeit within the normal range for other health care workers. However, confidence and self-reported competence improves. The challenge for UK EDs is to diminish the stress without reducing the learning outcomes.

USS for renal stones

I'm a big fan of POCUS (point of care ultrasound), but also rather skeptical as enthusiasm does not equal science. This month we have an interesting paper looking at the surgical outcomes of 500 patients who were scanned within 24 hours of ED admission. Although not really POCUS (as these were radiologists scanning) the sensitivity for surgical intervention was high. What we don't know is how an USS strategy might compare against the increasingly more prevalent CT strategies for the diagnosis and management of renal colic. For those working in areas where CT is unavailable this study may well help risk stratify patients.

Are guidelines good?

I frequently groan when the solution to every problem in the ED is another form, guideline or pathway, but perhaps my dismay at the formalization of medical care is unfounded. Perhaps guidelines really do improve care (I think they do really). Considering the ubiquity of guidelines it is perhaps surprising that they themselves have not been studied frequently. This month Ayobami *et al* evaluate the effect of introducing guidelines into a PED. Did it increase compliance? Yes. Did it affect the outcome of care? I'm not so sure as it did not alter return rates to the PED. We need more studies like this to assess the impact of process against clinical outcomes.

Whole body radiographs in acute medical emergencies

Whole body radiography has been around for some time and it's something we looked at years ago before access to CT improved in the UK. Its still used in many areas of the world and a systematic review in this month's journal looks at the evidence. Overall the review concludes that the system is equivalent to conventional radiography, but as we are using CT for many of these patients the generalizability needs careful consideration.

Can the VBG replace the ABG?

I've been lucky enough to hear Anne-Marie Kelly talk on the use of venous blood gases in critical care. She is a renowned world expert on the subject and this month she shares a review that has the potential to change clinical practice in many emergency departments. The ABG is not dead, but we may not need it quite as often as is traditionally taught.

Richer or poorer: who gets the CPR?

We know that bystander CPR is vital in the chain of survival from cardiac arrest. We also know that not enough people receive it even if people are present, but what factors might affect whether our patients receive bystander CPR. Moncur *et al* have looked at socio-economic status and show an association between high socio-economic status and CPR. The implications and solutions to this are unclear but may include targeted training to areas and populations with low CPR rates.

Does time affect shoulder enlocation success?

I've always prioritized shoulder enlocation in the ED, but largely on the grounds of analgesia and patient experience. This month Kanki *et al* give us another reason. In this retrospective review time delay also appears to make a difference with increasing failure with delay. It's more evidence to prioritize and manage these patients quickly (and of course safely).

Sexual assault and the ED

A disturbing Canadian paper from Sempsel *et al* reminds of the frequency and characteristics of sexual assault at mass gatherings. Although the data is collected from a sexual assault centre we must remember that victims can present to the ED seeking our help and we must be prepared to support them. However, French data from Denis *et al* examines the experience of sexual assault victims. The expectations of victims were frequently not met, especially with regard to psychological care. This pair of papers needs careful reflection and a consideration of how we might support our patients better.

Can we spot cardiac patients at triage?

The early identification of patients with suspected acute coronary syndromes is obviously important and we rely on the triage process to do this. Carlton *et al* show that nurses and doctors are equally accurate with high levels of sensitivity for major adverse cardiac events at 30 day follow up.

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