support the statement that ‘Many trauma centres in the US subsequently changed their policies to one of scoop and run’. The main finding of the paper was that mortality rate following trauma was not influenced by the pre-hospital administration of intravenous fluid. To suggest that pre-hospital activity is the only variable influencing outcome is simplistic and assumes that all patients have received the ‘gold standard’ in-hospital definitive care, an assumption that is unfortunately far from the truth. Jacobs et al. produced one of the rare papers that used a change in Trauma Score to identify the benefits of ALS procedures specific to the pre-hospital setting.

Most of the studies quoted had penetrating trauma as a significant component in their aetiology, a group in which there is a good body of evidence to support a calculated ‘scoop and run’ policy. It becomes more difficult in blunt trauma, predominant in the UK, to apply such principles or to identify the benefits of individual ALS skills. At present, appropriate use of pre-hospital skills in conjunction with expeditious transfer to hospital comes with experience gained by the pre-hospital care personnel. It should not be forgotten that these personnel must be able to perform procedures regularly in order to maintain the necessary skill levels.

The complexities of advising pre-hospital care personnel on the appropriateness of applying individual skills requires a close working relationship and understanding supported by regular feedback allied to good medical control. Being critical without being constructive risks undermining such relationships. Control and audit mechanisms for such personnel in the UK are still being developed but there should be little doubt that it is the responsibility of specialists in accident and emergency medicine to foster and support such processes.

We would suggest that audit and analysis of the use of pre-hospital ALS skills allied with building bridges with the emergency services leading to better communication and continuing education for pre-hospital personnel will help, not only in clarifying the appropriate use of these skills, but also hopefully lead to better outcomes.

REFERENCES

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Reduction of inappropriate attendances

I would be grateful if, through the Journal of Accident and Emergency Medicine, I could make a plea which may help to reduce some of the inappropriate attendances at accident and emergency (A&E) departments. This letter is written on a Sunday morning and I have just seen a child with a superficial burn to the arm. The burn was sustained 1 day previously and had been quite adequately assessed and treated at another hospital. The child had been referred and was told to come to hospital as soon as they got to Edinburgh for further treatment.

This visit is completely unnecessary. It is not our policy to review burns patients within a week unless something drastic has happened to change the situation. It would have been much simpler if the parents had been told to contact our department or their general practitioner (GP) who would be able to recommend follow-up on their return to Edinburgh.

This is not a single occurrence. We regularly see patients who have been told to attend when they return home to Edinburgh. As people often return from holiday in the evening or at weekends they naturally assume that they have to come to the A&E department as soon as they return. I would like to think that patients could be asked to contact the department or their GP by telephone so that appropriate arrangements for follow-up can be made.

There is little we can do in the A&E department at the weekend for fractures, wounds dressings or burns that could not be done over the telephone. Appointments can be made for the out-patient clinics if appropriate. Patients can then be seen by senior members of staff at a time when the staff and facilities are available for them and they can be dealt with in a much more appropriate manner.
I do not know if I am alone in noticing this problem but I would be grateful if through your columns we might instigate a debate as to how this policy might be taken forward.

T. BEATTIE
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Training in major incident planning

I was very interested to read the article by Brennan et al.1 I share their concerns that few doctors receive training in major incident management. Very few doctors will ever be asked to be medical incident officers by an ambulance service, but substantially more will be asked either to be part of a team sent to a major incident, or indeed a hospital medical team sent to any incident.

For the last year I have been teaching house and senior house staff of all specialties at this Hospital how to be part of a major incident team. The lecture is designed to dovetail with the plans of the London Ambulance Service, and to familiarize doctors with the command and control structures of the three main emergency services as well as to outline what is expected of the individual doctor.

As far as I am aware this is the only teaching aimed specifically at members of a mobile medical team. The lecture has proved very popular with junior staff, and I would support Dr Brennan’s call for improving training of staff in major incident support.

REFERENCE


R. COTTINGHAM
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Contamination of clothing in accident and emergency departments

I would agree with Mr Steedman that the contamination of skin and clothing of staff working in accident and emergency (A&E) departments is both unacceptable and unhygienic.1 The problem is not only confined to major inner-city departments, as illustrated by the findings of survey where medical and nursing staff in the A&E department at the Royal Alexandra Hospital Paisley, a district general hospital, reported 51 splashes in a 4-week survey period during which 4692 patients were treated.

Staff most frequently splashed were A&E nurses with 51% of reported incidents (26 splashes), followed by A&E doctors at 35% (18 splashes). The remaining 14% (7) were to medical and surgical receiving staff. A total of 76.5% of splashes (39) involved blood. Although 2.6% of patients (124) were seen in the resuscitation room, 21.5% of splashes (11) occurred here. Suturing and wound management proved to be the most common cause of contamination accounting for 41% of splashes (21), which involved the trunk area in 51% (11). The practice of inserting an intra-venous cannula and withdrawing blood samples through the cannula accounted for a further 39% (20) of splashes and, of these, ungloved hands were splashed in 85% (17 incidents).

Both nurses and doctors working in A&E departments should wear protective clothing and the importance of universal precautions needs to be emphasized firmly. Many splashes could be prevented if gloves and plastic aprons were worn whilst assessing wounded patients, suturing and in the resuscitation room. Gloves should always be worn during intra-venous cannula insertion and blood sampling.

REFERENCE


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Head injuries in the accident and emergency department

I read the article by Dr S.A. Wallace et al. with great interest.1 I agree that criteria for adults when ordering skull radiographs following head injury should be modified for paediatric patients.

I would like to bring to the attention of readers recently published guidelines for skull radiographs in paediatric patients with head injury.2 These are an intrinsic part of the Advanced Paediatric Life