The authors reply
The aim of the paper was to evaluate whether an experienced trained nurse can treat minor injuries and ailments in a minor injury unit and not to justify the existence of such units. However, if healthcare trusts decide to commission a unit the year’s study has shown that ENPs can be used to provide a successful alternative service.

The points raised by Mr Leaman are arguments that can be used against the existence of minor injuries units, which might well be valid, however this is not what the authors intended to raise this paper.

All patients who attended the unit were initially assessed and treated by the ENPs. Patients who were referred to the consultant were patients who required follow up and would have been referred even if they had been treated by a casualty officer. It is true that a high number of patients were reviewed in the unit. This is because the consultant has an interest in the management of the common fractures that do not require orthopaedic intervention.

In order to monitor the ENPs work during the year of evaluation, all the patients’ notes were reviewed by the consultant to assess whether patients had been diagnosed correctly and treatment had been carried out according to protocols set. Reviews of patients served to monitor the effectiveness of the treatment given by the ENPs.

As to not having kept a record of how many patients treated by the ENPs then self referred to a GP or an A&E department... Is it possible to keep records of this without a national integrated monitoring system? Patients self refer for second opinion all the time regardless of where they have been initially treated.

Risk of fire outweighed by need for oxygen and defibrillation

The authors reply
We were pleased to find that McAnulty and Robertshaw’s work regarding oxygen concentration during simulated cardiopulmonary resuscitation1 confirms our research, and are grateful for the opportunity to discuss our methodology in greater detail.

With the manikin and ventilation bag set up as explained in our previous letter,1 the oxygen level recorded at the sternum and apex paddle positions and also at the mouth remained at 21%. Each position was observed for 10 minutes and the oxygen reading was noted to stabilise after two minutes. Therefore, with the analysis raised above the trolley around the manikin’s anterior, there is no change in oxygen concentrations.

Referring to both our earlier letter on the subject and supporting letter by Dr Ward,1 the real debate is not how far to remove the ventilation bag before defibrillation but whether one should remove the oxygen at all before defibrillation. Which is the greater risk? The risk of fire due to defibrillation over an oxygenated area, or the risk of dislodging the endotracheal tube, reducing oxygen flow to a patient in dire need, and delaying life saving defibrillation?

As a training issue, we concur with Dr Ward, “awareness of the problem is likely to reduce the incidence [of fire],” and Robertshaw and McAnulty, “it is most important to avoid arcing by ensuring correct placement of paddles and electrolyte pads before defibrillation...”

In summary, the risk of fire is remote in properly performed defibrillation; the risks to the patient caused by taking the time to remove the oxygen, and the possibility of dislodging the endotracheal tube before defibrillation are too great. Whether in the accident and emergency department or the intensive care unit, we reaffirm our belief that oxygen should not be removed before defibrillation.

Child Protection Register—time for change

The authors reply
The Child Protection Register neither protects children nor is it a good register. It is used in accident and emergency (A&E) departments across the country several thousand times a day as an investigation. What is the sensitivity and specificity of this test, what positive or negative predictive value has it got? Many, if not all, A&E department clinicians...