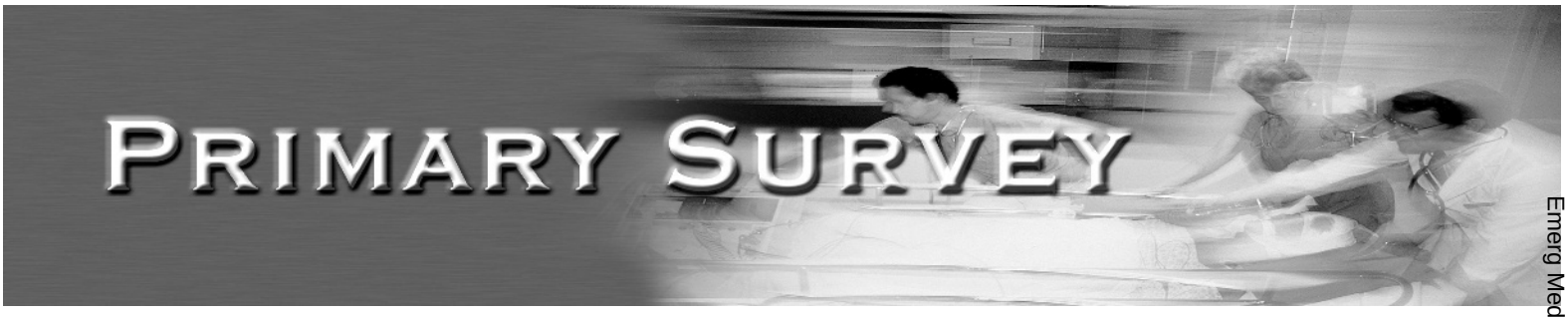

Kevin Mackway-Jones, *Editor*

GETTING THE BASICS RIGHT

Big drips are one of the hallmarks of emergency department care. You can't go wrong with one—the bigger they are the better prepared you are for any emergency. Well, as Matthew Reed shows in his neat little study, you can go wrong with them; big drips mean big dead space, which can mean considerable delivery delay for time critical drugs. Sometimes small is better. Think pink (or blue).

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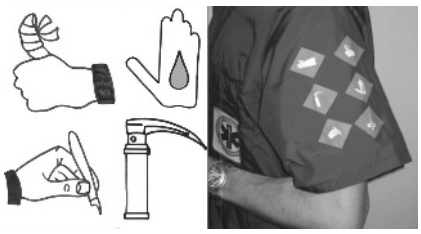
SCOUTING OUT GULLIBILITIES

As I write this there has been no response (rapid or otherwise) to the short report ''Scouting out competencies'' (*Emerg Med J* 2007;**24**:286–7) published in April's edition of this journal. The lead author of that article has written to express surprise at this lack of response. A further clue is necessary and the following has been suggested: ''Olaf Plori, mixed up author has the first laugh of spring''. A badge for the first correct answer. You can put it on your scrubs.



COMPETENCE TO ASSESS CAPACITY

With the first implementation of the new Mental Capacity Act upon us, it is timely to consider just how competent we are at assessing capacity. Katherine Evans and colleagues have used a structured questionnaire to investigate this. Their findings make worrying reading—with a third of doctors, 90% of nurses and all ambulance staff failing to answer questions on this subject correctly. As the authors note these findings indicate an urgent need for further (or is it initial) training of emergency workers in this area.

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HOW OFTEN IS TOO OFTEN?

Over the years many groups have considered the problem of frequent attendance to the emergency department. A fundamental issue in any discussion is the definition of this group. In simple terms how often do you have to attend before you get the label? Thomas Locker and colleagues have taken a statistical approach to this question and come to the conclusion that more than four times in a year defines this group. Those who pass the threshold have significant differences from those who do not—most particularly they have double the admission rate. Other countries in Europe have very different emergency department usage rates from the UK and it would be interesting to see a similar analysis from one or more of them.

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EARLY GOAL DIRECTED THERAPY—5 YEARS AFTER RIVERS

Narani Sivayoham presents a short report of a survey that looks at the delivery of emergency department based early goal directed therapy in England in 2006. It is unsurprising, but still somewhat depressing, to find that only 18.8% of the responding departments had the wherewithal to start treatment. It is likely that this is an overestimate as the usual response biases will apply. If we can't do this then what can we do well?

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TETANUS IMMUNISATION KNOWLEDGE

Not tetanus immunisation by the look of things. Emma Savage and colleagues report the results of a survey into the knowledge of medical and nursing staff in this area. It is (again) surprising that 22% of respondents would consider any wound tetanus prone, and a wakeup call that nearly half of respondents would prescribe a booster injection in patients who have completed a primary course and had had two previous boosters. It's education, education and education. Again.

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STOPPING SUPERFICIAL BURNS HURTING

What works best to reduce the pain of superficial burns? Anne Welling reports the results of a randomised controlled trial designed to compare the analgesic efficacy of a water-based gel containing either morphine or sterile water with a jelonet dressing control. Which do you predict would work best? Read the study and see if you get a surprise.

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