

Highlights from this issue

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We are all busy

Is the ED busy? We all 'know it when we see it', but Beniuk *et al* report on a Delphi to determine metrics that can quantify the level of crowding. The eight consensus parameters are no surprise; they seem to mirror the performance reporting that is currently required of us in the UK. The interesting bit is that this comes from an international panel; perhaps we ARE looking at the right things (*see page 868*).

When we are busy, the error rate rises. When we are interrupted, the risk increases further. Allard *et al* report on a simple observational project around the role of an emergency consultant 'on the floor'; the type and frequency of interruptions and the effect on efficiency. Analysis of a single person in a single environment so comes with a health warning, but it does make you think (*see page 872*).

To handle patient surge, we rely on systems and processes; but are they safe? Can patients be safely streamed to Primary Care from ED triage using our current systems? Van-der-Straten *et al* suggest that it can (*see page 877*).

Some global health context

Next time you have a queue, spare a thought for systems in a more global context. Harrison *et al* describe an initiative in Africa to create order from chaos by the introduction of an Emergency Department and a triage system at a hospital that didn't have them. 315 000 undifferentiated patients a year with three doctors! The staff feel more in control, but this must be relative and the truth about a change in outcomes is yet to be told (*see page 925*).

Data is the key to understanding the effect of change but when you are overwhelmed, this is the last thing on the 'to do' list. In the context of a developing health care system, introducing the detailed measures that are used by more established

systems seems doomed to fail. Sun *et al* suggest that a simple physiology based scoring system might allow demonstration of changes to outcomes. TEWS might just be that tool (*see page 882*).

Getting the basics right

Airway comes first. Active intervention to manage a potential airway problem in the trauma patient is well established. Nielson *et al* suggest that the correlation between airway protection and level of consciousness is less clear in the medical scenario and that the threshold for intervening should be different (*see page 887*).

Sharma *et al* show that we potentially have a problem with being able to provide an essential intervention (*see page 927*). Trans-venous pacing can be life-saving in a resuscitation situation but the availability of people competent to do it is open to question. Is it something that should be highlighted in the curriculum?

The threshold for CT scanning of head injured patients has fallen over the years but it does need to be balanced against the increased exposure to radiation. Sheehan and Batchelor show that there is no simple answer and argue that the NICE guidelines need to consider this information in the next revision (*see page 899*).

Pain relief is the one thing that we should always be able to provide well. Serinken *et al* report on an RCT looking at options for managing renal colic (*see page 902*) and Sacchetti *et al* suggest that Remifentanyl should be more evident (*see page 929*).

Cooke *et al* provide a reminder of that first and basic medical school lesson: listen to the patient! If they have fallen off their bike and have suffered traumatic injuries, don't make a causal assumption. Did the patient fall and lose consciousness? Or did they lose consciousness first? It just might be the reason they fell! (*see page 920*)

Pragmatic pre-hospital care

Some good ideas just don't work. Segal *et al* report on an experiment for managing a cardiac arrest whilst in a dental chair. Using an accelerometer to inform on the quality of chest compressions to ensure good compressions? It doesn't work. Ambulance crews are taught to bring the patient to the floor to provide effective massage; perhaps dentists need the same message (*see page 890*).

The use of oxygen in patients with COPD and poor saturations was significantly changed by the introduction of the British Thoracic Society guidelines. However, these patients frequently need nebulised medication and the only gas available to paramedics to drive this is oxygen. Edwards *et al* show that there is a significant increase in carbon dioxide retention during treatment and that the longer it is used, the worse the change (*see page 894*). Compressed air is not available on an ambulance; perhaps the time is coming where we should consider introducing compressors as part of the therapeutic repertoire?

Having shown their difficulties with limited equipment, the innovative skills of the paramedic can be quite impressive. Fitzpatrick *et al* show what can be done to effectively merge two treatment modalities when faced with a challenge. When you know the answer, it is simple and obvious, but to think it on your feet? (*see page 922*)

A little too far?

Helm *et al* show an interesting example of a complication of using an intraosseous needle device (*see page 924*). The picture is cool! Then read the narrative again and the circumstances in which the device was deployed. I know about the military maxim 'train hard, fight easy', but surely there must be limits to engagement with simulation! On the other hand, I can think of some 'volunteers' to try it on ...