Triage and mortality
This is one of a range of studies we have published in the EMJ regarding the performance of emergency department (ED) triage scores. In this study, the researchers found that a quick ‘eyeball triage’ performed better at predicting mortality than the more formalised (and researched) Danish Emergency Priority Tool (DEPT). At first glance, this might suggest that rapid triage by relatively less qualified staff is ‘better’ than formalised triage, but we need to be cautious, very cautious about such conclusions. When we look at triage tools, we should assess them on what they are designed to do. DEPT was not designed to predict mortality, but rather the need for urgent intervention which is only loosely associated. Whether eyeball triage has a place in our departments remains an interesting question, but first we should define what we want it and its comparators to do.

Juicing, squeezing and returns of redirection
All UK and I suspect that all international emergency physicians will have suffered and been angered by arguments that most patients can be treated in alternative locations. While we all agree that some patients can be redirected, there are disagreements about the proportion and range that can be safely seen elsewhere. It often feels that the redirection bandwagon is led by politically and arguably discriminatory policy. This study is a systematic review of the evidence of redirection policies and, to no great surprise, in my opinion, there is little evidence of any effectiveness. This finding matters as we should be focusing our efforts on strategies that work and/or do support the system. Throwing money at redirection policies that are not evidence-based or shown to be effective is merely a waste of resources.

Alcohol, jail and sobriety
We have an interesting paper this month that once again shows how the ED must once again shows how the ED must deal with. The sobriety programme found that a quick ‘eyeball triage’ performed better at predicting mortality than the more formalised triage programme. In this study, the researchers found that a quick ‘eyeball triage’ performed better at predicting mortality than the more formalised (and researched) Danish Emergency Priority Tool (DEPT). At first glance, this might suggest that rapid triage by relatively less qualified staff is ‘better’ than formalised triage, but we need to be cautious, very cautious about such conclusions. When we look at triage tools, we should assess them on what they are designed to do. DEPT was not designed to predict mortality, but rather the need for urgent intervention which is only loosely associated. Whether eyeball triage has a place in our departments remains an interesting question, but first we should define what we want it and its comparators to do.

An approach to syncope in the ED
Matthew Reed is a true expert in the investigation and management of syncope. The EMJ has been privileged to publish several of his articles over the years, and we are delighted that he has put his expertise down on paper in this informative and evidence-based review of syncope management. It is a complex area that has caught many of us out in the past (it has caught me out at least), and it is clearly in need of a systematic approach. There are some excellent examples and strategies in this paper and I would strongly recommend a read and share of the advice here.

Variation in subarachnoid bleed workups
We know that clinicians vary, especially when tackling diagnostic conundrums such as suspected subarachnoid haemorrhage. What we do not always understand is why. This is a great paper that takes a qualitative approach to find out why clinicians vary. This is important for all of us as clinical decision-making is a key aspect of variation and overall quality. Perhaps I like this paper because it reinforces my beliefs, for instance, that clinicians involved in what is depicted as shared decision-making may steer the conversation to the a priori beliefs… you know we do this…!

Does ED length of stay affect mortality for our sick patients with sepsis?
I am sure we have all had intensive care unit (ICU) patients board in the ED. Capacity for ICU beds is limited and there will always be times when patients wait in the ED. In this paper from China, the authors have found a link between mortality and time spent in the ED. There are complexities here around the patient mix, but they have tried to control for this and still find an association. The question for us is why this is and whether it can be mitigated. I am a big fan of the ‘upstairs care downstairs’ concept that states that we should be able to deliver ICU care in the resus room. Whether we can, whether we should and perhaps whether we will continue to have to are all up for debate. I do not think this study proves that ED care is poor, but it does tell us that we need to be vigilant that resuscitation does not stall in the resus room while waiting for an ICU bed.

MRSA in the ambulance
There is a short report this month on the potential for ambulance equipment to act as fomites for methicillin-resistant Staphylococcus aureus (MRSA) infection. Unsurprisingly, the answer is yes and that is a real concern. What we do not know is what we can effectively do to stop this and how generalisable the findings are. What is of interest is that it is not always the most obvious pieces of equipment that may harbour MRSA, oxygen cylinders for example, which tend to be touched by clinicians rather than the patient.