other kinds of loss. This may be part of the role of community psychiatric nurses in A&E departments.

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A simple to use audit for Accident and Emergency Departments

Sir

Medical auditing is quickly becoming established in all branches of hospital practice.

It should provide a basis for quality control as well as a record of the number and types of patients treated.

Studies have been made of the seriously injured, but by far the larger part of the workload of an Accident and Emergency Department is with patients who are not severely ill. An auditing system is therefore required which can cover the management of the whole range of conditions presenting to the department, not just the life threatening illnesses and injuries.

The auditing system must also take into account the vast numbers and diversity of patients attending, and also the 'sorting house' nature of the department.

At the Royal Preston Hospital we have developed a method of audit which is fulfilling these aims.

Fifty-eight thousand new patients annually attend our Accident and Emergency Department. It would not be practical to review every patient's treatment in detail. Therefore every fiftieth adult and every fiftieth child is included in the audit. This averages a total of 97 patient records audited per month.

The casualty notes are assessed on a form which covers patient waiting time, reason for attendance, disposal of patients and also a value judgment of the completeness of the triage nurse's and doctor's notes, and the treatment given to the patient.

When required detailed comments are then made on a separate sheet, where again the patient is identified by his or her casualty number only. These comment sheets form the basis for the regular audit meetings.

Any deaths which occur in the department are also assessed on the comment sheet, together with the information from the post-mortem results. This allows the management to be critically evaluated, and any avoidable factors identified for future action.

A master sheet is useful for the compilation of monthly figures for future comparisons. This gives useful statistical information, plus information on the percentage of the doctor's and nurses notes which warrented further comment. It highlights where the quality of service can be improved, by revealing the frequency and severity of the omissions which have occurred.

Due to the inclusion of the subjective value judgment of the quality of treatment given, the audit should be performed by the same senior member of staff over a number of months.

In an Accident and Emergency Department of our size, a time commitment of one person for 1–2 h a week will cover the assessment of the casualty notes and the collection of the data.

It is too early to see if the regular feedback, which this auditing system gives, leads to lasting improvement in the quality of the service we give to the public. However, the way in which medical auditing encourages a critical attitude to one's own work should improve each individual doctor's future performance.

Copies of the forms used in this audit method may be obtained from the Accident and Emergency Department of the Royal Preston Hospital.

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Is anaesthesia necessary for reducing shoulder dislocation?

Sir

I read with interest the article by A.Banerjee (*Archives of Emergency Medicine*, 1990, 7, 240) and would agree with him that anaesthesia is mostly unnecessary for the reduction of dislocated shoulders. However, I feel that withholding analgesia from patients with a notoriously painful condition is not an advance in emergency medicine practice.

Delays in treatment will undoubtedly occur even in the best organized departments, and many will have to wait for an X-ray examination. Although the technique as described can be used to effect immediate reduction in those not