The College of Emergency Medicine

Emergency Medicine in the UK - What is emergency medicine?

Emergency Medicine was defined by the International Federation for Emergency Medicine in 1991 as:

"A field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development."

Emergency Medicine Key Facts

- **1 in 1000 with major trauma**
- **1 in 100 with acute life-threatening illness (75% acute medical)**
- **1 in 7 are admitted as an in-patient**
- **1 in 700 dies in the Emergency Department**
- **1 in 4 is a child**
- **9 in 10 attended without first seeing GP**
- **1 in 4 do not require the facilities of an Emergency Department**

Emergency Medicine Speciality Specific Curriculum

Contents

Clinical Standards Advisory Group.

Emergency and urgent admissions to hospital.

London: HMSO, 1995.

Emergency delays need urgent attention

Nearly one in five patients needing emergency treatment in British hospitals experience a delay in admission, says a report from the Clinical Standards Advisory Group published last week.
In just over 40% of cases the delay was due to a lack of beds, but in one in six cases it was due to no doctors being available.

The acute care problem (historically)

- McQuillan P BMJ 1998
  Causes of suboptimal care prior to ICU were
  - failure of organisation / lack of knowledge
  - failure to appreciate clinical urgency
  - lack of supervision / failure to seek advice

- NCEPOD An Acute Problem 2005- patients who died
  - Poor management of
  - Airway (11%), Breathing (16%), Circulation (14%), Monitoring (13%)
  - Oxygen therapy 14%

- The most worrying domains were
  - ability to seek advice 30%
  - appreciation of clinical urgency 21%
  - Lack of supervision 28%

The Clinical Standards Advisory Group, an independent expert body set up to advise the government on standards of clinical care, found that hospitals that admitted most of their emergency patients within two hours had a lower mortality at 28 days.

NCEPOD

2007 report

Emergency Admissions:

a journey in the right direction?

Overview of findings - 1

- 34.8%
  - Remediable factors in standard of care
    - Not all would have affected outcome
- 7.1%
  - Initial assessment poor or unacceptable
- 15.1%
  - Admitting units without 24/7 radiology provision
  - 4.8% patients reviewed delay in obtaining results

Overview of findings - 2

- 68.8%
  - Consultants with other duties when on-take
  - 21.2% undertaking more than three duties
- 12.4%
  - No documentary evidence of review by Consultant
  - 50% unable to determine time to first review
  - Where recorded 40% not seen within 12hrs
- 6.8%
  - Patients did not receive adequate observations

Principal Recommendations - 1

- Initial assessment
  - Sufficient experience and seniority to implement management plan
- Patients admitted as emergencies
  - Seen at earliest opportunity by Consultant
  - Ideally within 12hrs
  - Not more than 24hrs
- Documentation of first Consultant review clearly documented in notes

Principal Recommendations - 2

- **Trainees need adequate training**
  - Recognise critically ill
  - Make clinical decisions
- Consultant job plans
  - When on-take, should be available to deal with emergency admissions without undue delay
  - When on-take, should be limitation of other duties
- Radiology
  - 24/7 access including CT
  - Immediate reporting

Principal Recommendations - 3

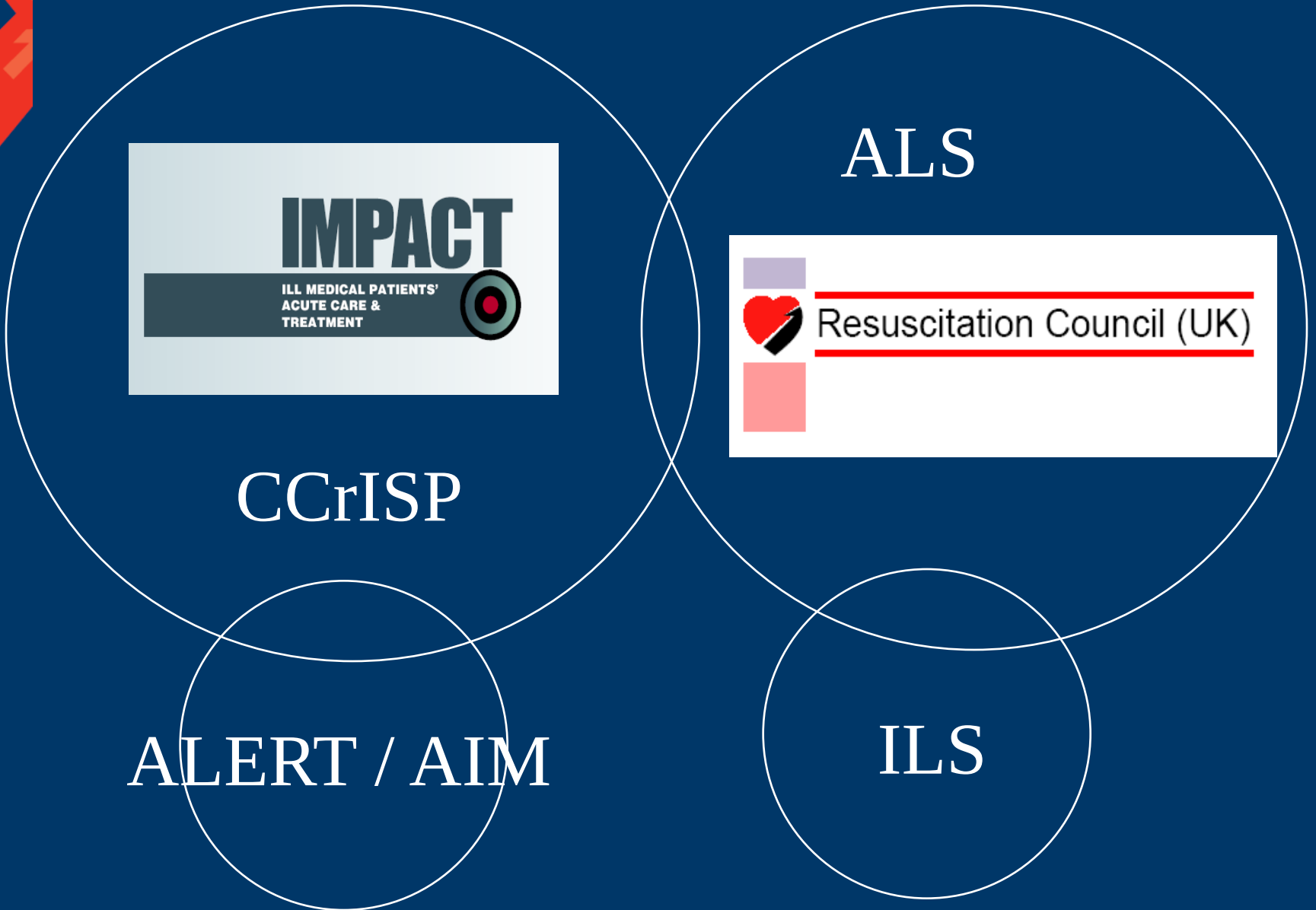
- Following assessment and treatment
  - Inpatient transfer to ward appropriate to clinical condition
- Excessive transfers between wards should be avoided
- Robust systems for handover
  - Protocols
- Physiological monitoring plan
  - What to monitor
  - Desired parameters
  - Frequency of observations

➔ **What about**

IMPACT

ILL MEDICAL PATIENTS' ACUTE CARE & TREATMENT

Comparing IMPACT with other courses



NHS
National Institute for
Health and Clinical Excellence

Quick reference guide

Issue date: July 2007

Acutely ill patients in hospital

Recognition of and response to acute illness in adults in hospital

Nursing & Midwifery Council

General Medical Council

Openness and honesty when things go wrong: the professional duty of candour

The professional duty of candour[1]

Every healthcare professional must be open and honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that healthcare professionals must:

- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient's advocate, carer or family) the short and long term effects of what has happened.

Healthcare professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns.

About this guidance

The Triage Nurse

Needs to be:

- Knowledgeable
- Skillful
- Educated
- Professional
- Accountable

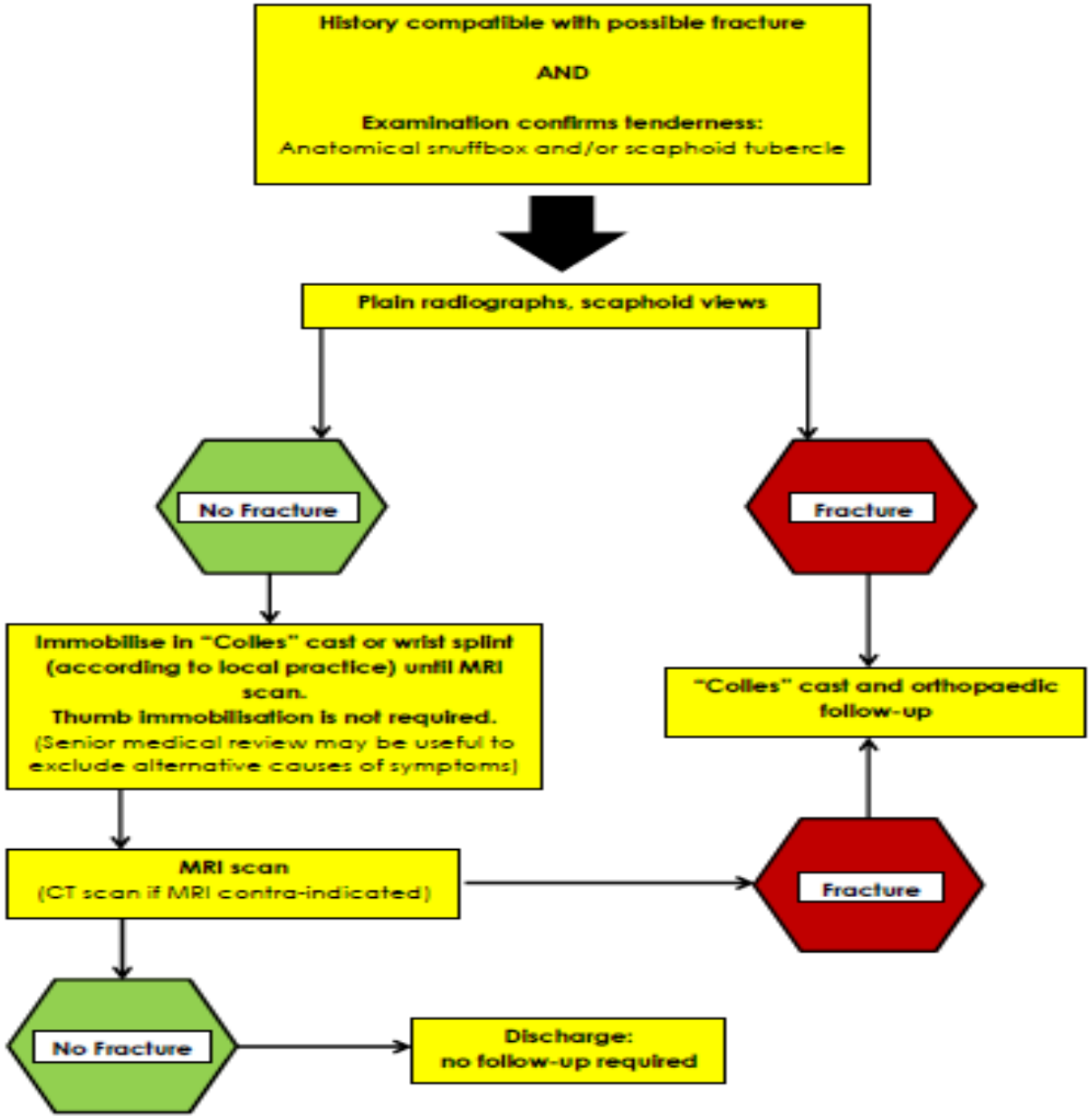
The Risk's @ Triage

- Chaotic environment
- Undifferentiated patients
- Access block
- Shear volume
- Stress
- Human factors
- Patient factors

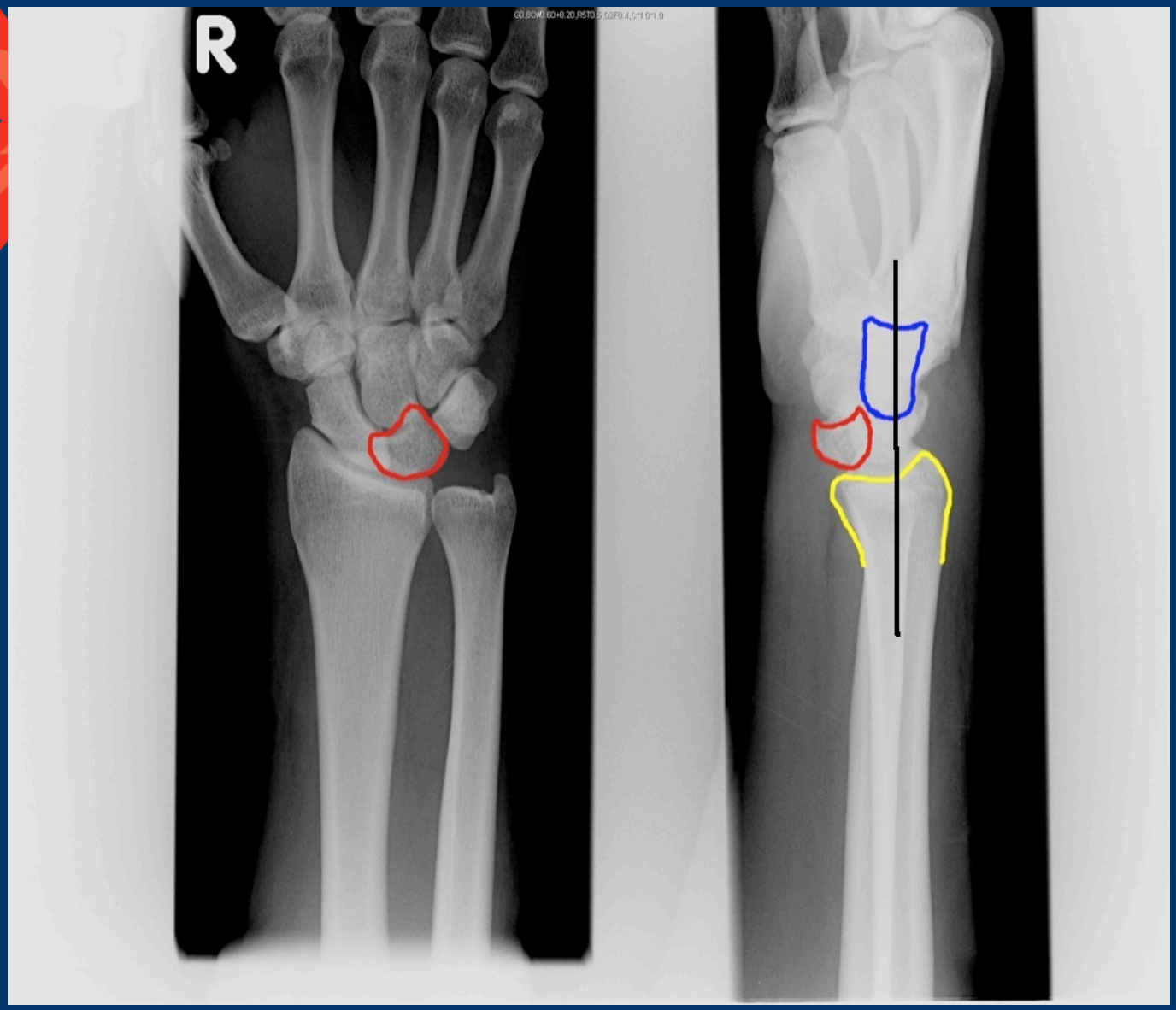
Negligence

- "Nurses have a responsibility to behave in a reasonable manner"

GEMNet: Management of Suspected Scaphoid Fractures in the ED - Evidence-based flowchart




Scaphoid Fracture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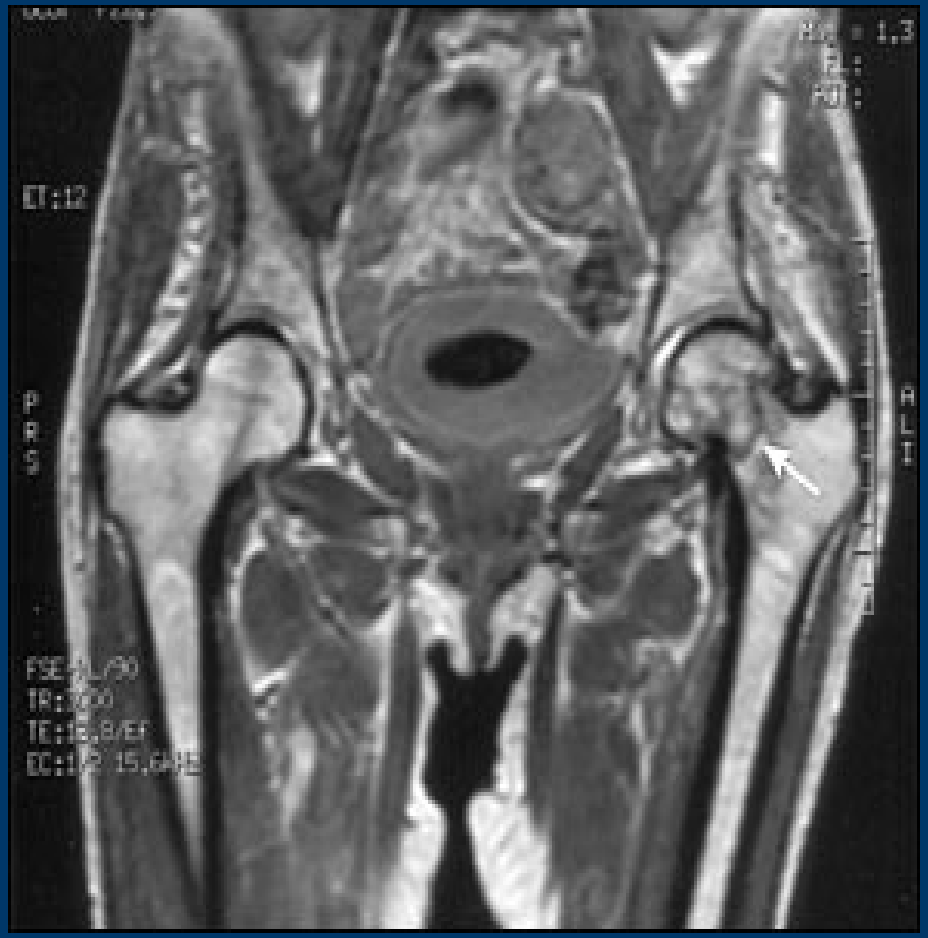
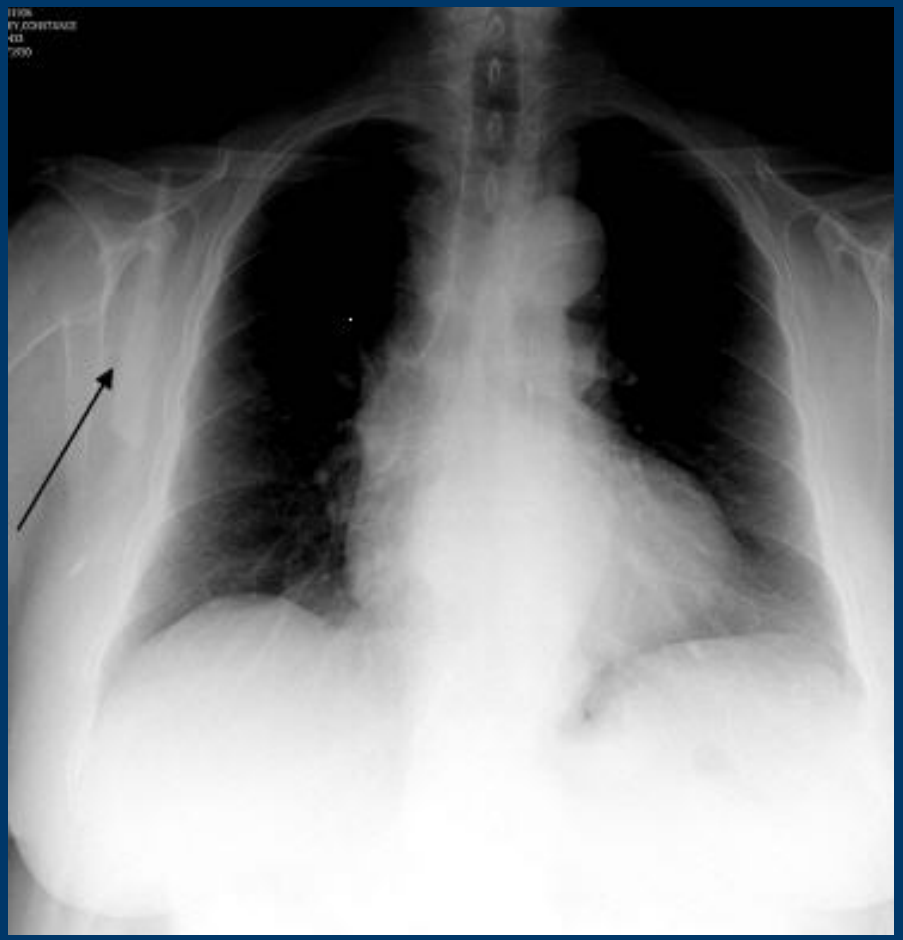
HIP

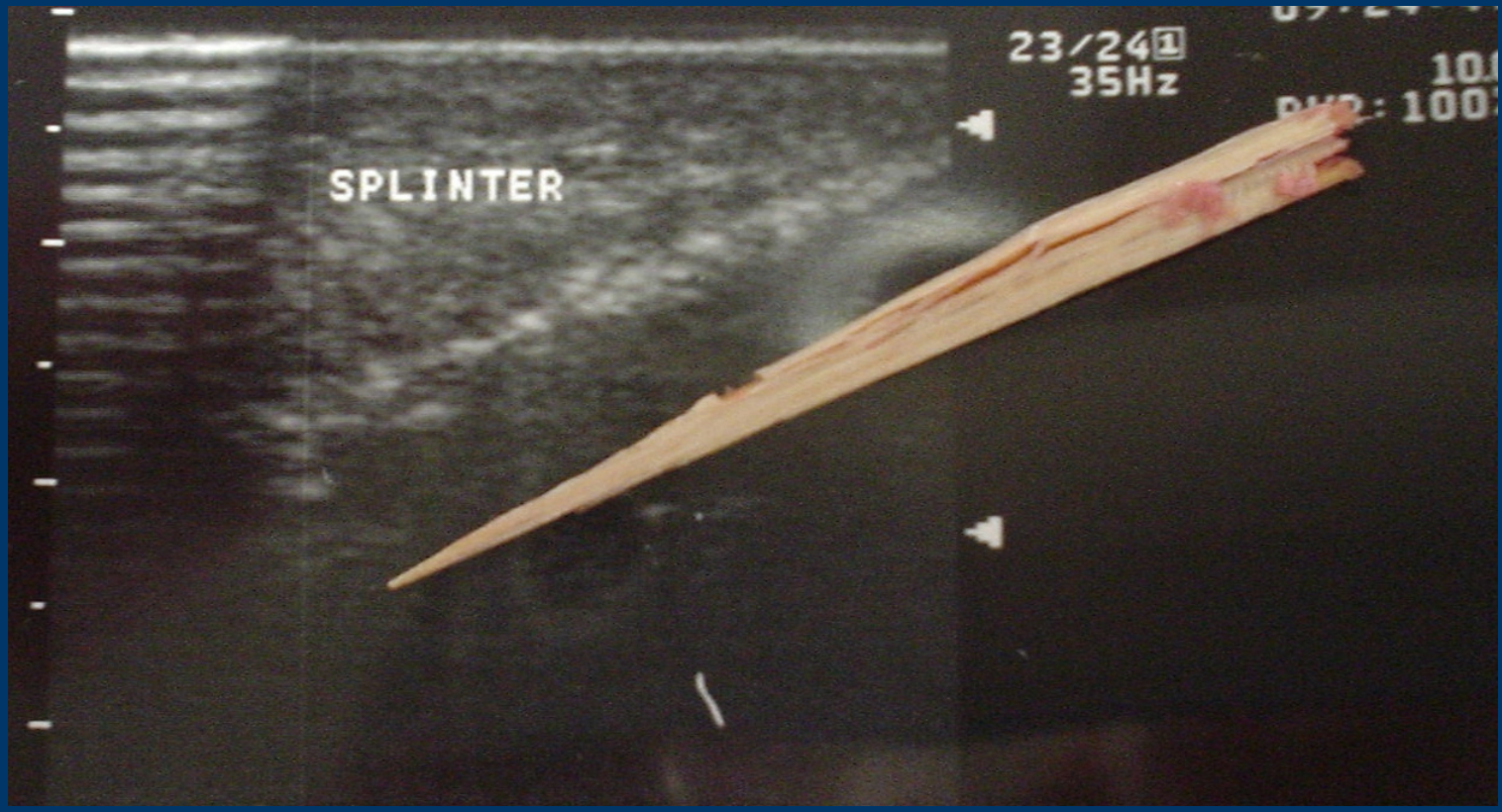
HIP - MRI



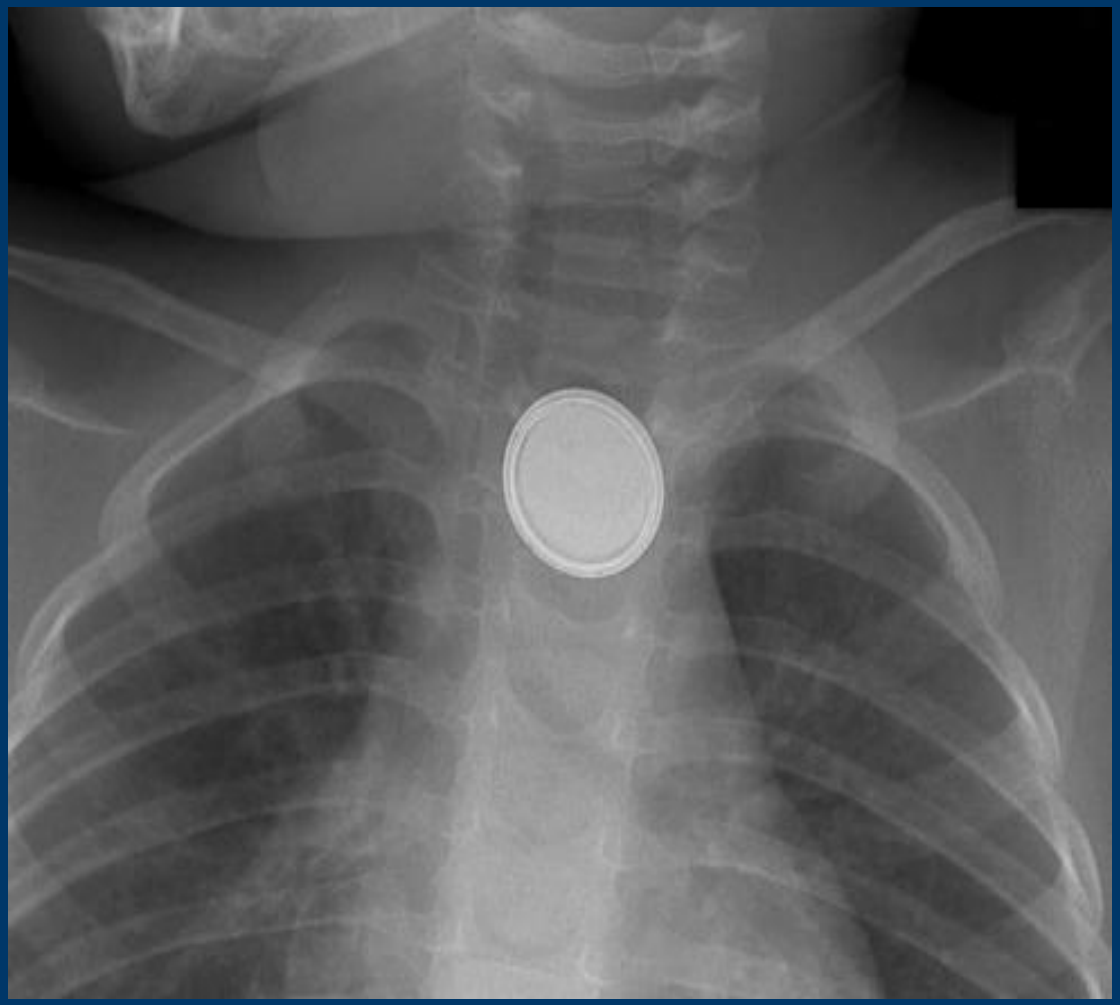
Glass fb



Wound infection

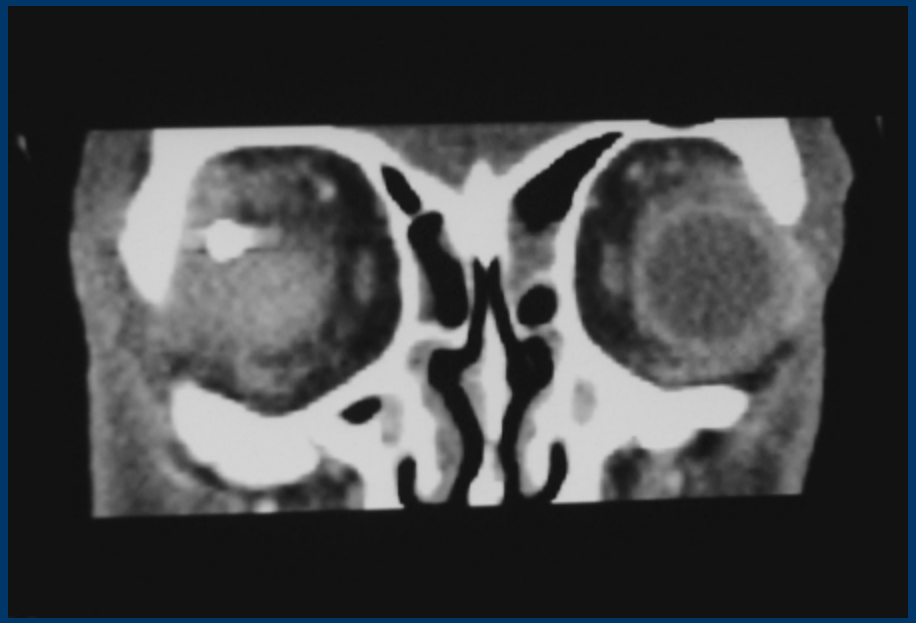


Swallowed Fb



Nasal Fracture

Eye



TOP 10 TIPS

for keeping patients safe

The College of Emergency Medicine

1. If you see something unsafe - or potentially unsafe – do something about it **NOW**
2. If it doesn't feel right – **get help**
3. If you don't know how or what to do – **ASK**
4. Prior to any procedure or the administration of drugs, **check**: right patient, right dose, no allergies and name band in place
5. **Believe** the patient/relative
6. Take **particular care** with high risk patients (e.g. the apparently-intoxicated, the elderly, young children, patients with language barriers/learning difficulties)
7. **Review** all relevant and available information on the patient (e.g. ambulance patient report form, previous notes)
8. **Review** the results of any investigations that have been ordered **before** the patient is discharged
9. **Listen** to the patient and encourage them to participate in their safety
10. Use a **structured** approach to communication, such as SBAR (Situation, Background, Assessment, Recommendation)

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Confidential Enquiry report
May 2014

Commissioned by:

Asthma

e is given for follow up.

References

1. BTS/SIGN Asthma Guideline

ording to the local policy

References

1. MHRA
2. National Poisons Information Service (Toxbase and Paracetamol Poisoning Assessment)

Radiology (under review)

Severe Sepsis and Septic Shock in Adults

[ix] Survive Sepsis, 2009

Emergency Ultrasound

Ultrasound: Skills of carrying out Abdominal Aortic Aneurysm Assessment (AAA)

Red Flags

Acute onset of pain which awakens the patient from sleep

Pain that is continuous or steadily worsening

Pain radiating into the back

Shock

Ultrasound: Skills of carrying out Abdominal Aortic Aneurysm Assessment (AAA)

Pitfalls

- There are many pitfalls in AAA scanning, predominantly by not assessing the patient clinically.
- Be wary of diagnosing ‘renal colic’ or musculoskeletal back pain in any patient over 60 years of age without first excluding AAA. Any patient, presenting with renal colic in this age group, should have an ultrasound scan to ensure that the aorta is non-aneurysmal.
- Do not exclude an AAA unless the whole abdominal aorta and proximal iliac arteries have been visualised.
- At all times think about the history and context, and ensure you are attempting to answer a legitimate question.

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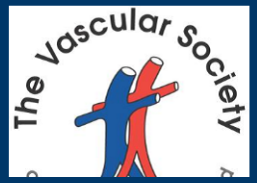


Transfer to a specialist vascular centre should occur within 30 minutes of diagnosis.

Summary of recommendations rAAA

A clinical diagnosis of ruptured abdominal aortic aneurysm (rAAA) should be considered:

In patients over the age of 50 years presenting with abdominal/back pain AND hypotension

In patients with a known AAA and symptoms of either abdominal/back pain OR hypotension/collapse

In patients where an alternative diagnosis is considered more likely on clinical grounds, rAAA still must be excluded, with radiological confirmation made prior to referral. *Level 3, strong recommendation*

Management rAAA

Emergency management of rAAA in a hospital without a specialist vascular centre has six steps.

Diagnosis

Assessment of suitability for transfer

Referral to a vascular specialist

Monitoring and treatment in the emergency department

Transfer to the vascular specialist

Further management by the vascular specialist (repair and subsequent inpatient care).

A6.1: Vascular Emergencies - Arterial

Objectives	Knowledge	Skills / Attitudes	Learning	Assessment
To be able to under-take a history and examination focussed on the vascular system and identify those conditions that threaten life or limb.	The symptoms, signs, presentation, causes and treatment of peripheral ischaemia, abdominal and thoracic aortic aneurysms and aortic dissection. Mesenteric ischaemia. Intra-arterial drug injection Traumatic vascular injury and associated fractures/dislocations.	To be able to resuscitate, use appropriate investigations (bed side, ultrasound and CT) and to ensure timely referral to appropriate specialist.	LP LT GT PS ODA	OC DOPS CBD ME FCEM MCEM

07

Resources

Us

r

Please be aware that this version of the curriculum is currently work in progress and is not complete.

CEM - Curriculum - Specialty specific skills curriculum - Vascular Emergencies - Venous

Print This Print All Subsections

< Previous Next >

Search : go clear

A6.2 Vascular Emergencies - Venous

Objectives :
Differential diagnosis of the painful / swollen calf.
Venous occlusion / DVT

Knowledge : more

Skills : more

Assessment : more

Method of Learning : more

A6.2: Vascular Emergencies - Venous

Objectives	Knowledge	Skills / Attitudes	Learning	Assessment
Differential diagnosis of the painful / swollen calf. Venous occlusion / DVT	Investigation and management of DVT including role of risk stratification, d-dimers and ultrasound. Proximal vein thrombosis	Focused clinical examination to establish most likely diagnosis	LP LT GT PS ODA CDU/ODB	OC MC CBD AUD ME FCEM MCEM

Venous emergencies

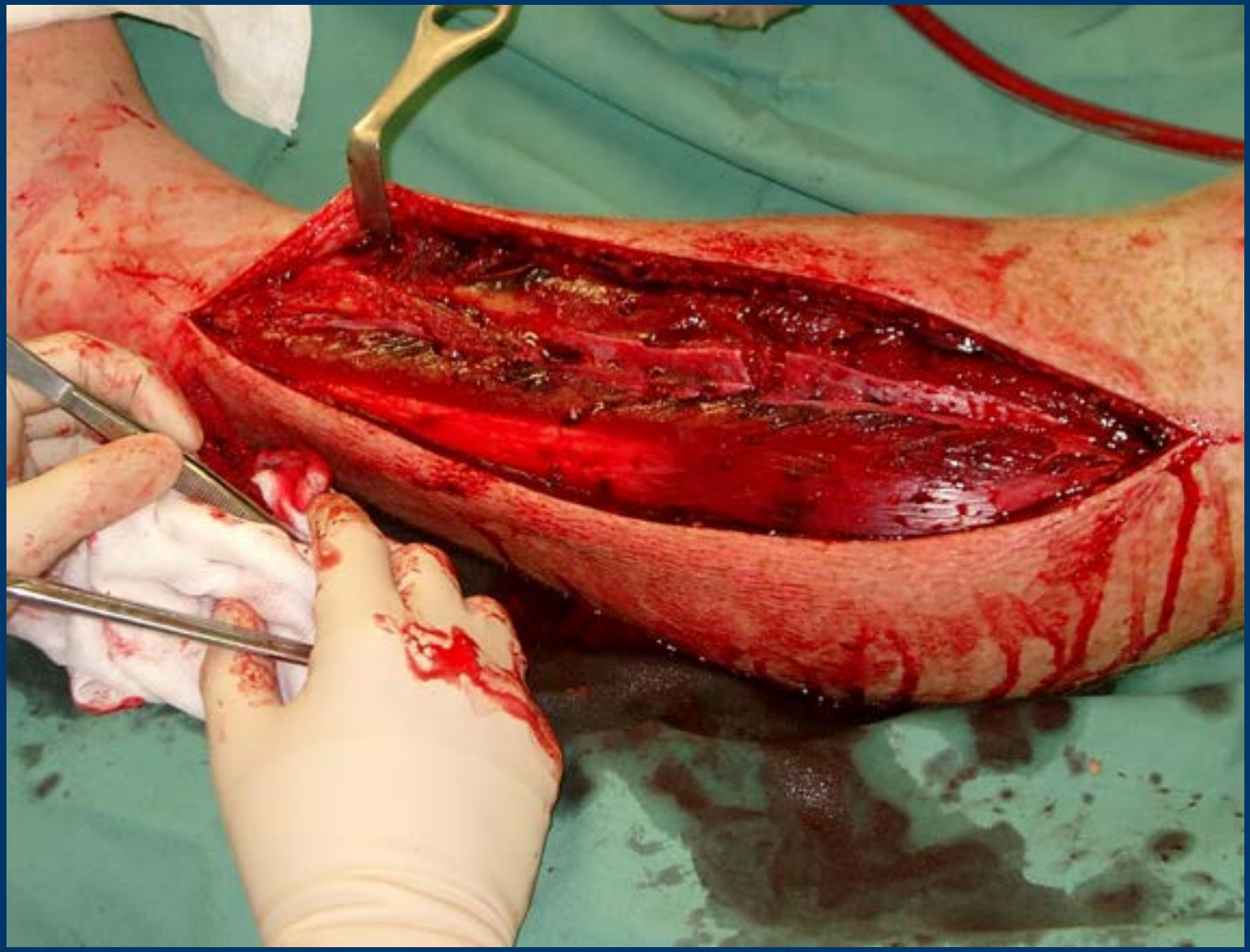
20 year old
Painful swollen calf

Rule out Deep Vein Thrombosis

D-Dimer

Clexane

Review for Doppler on Monday



Problem	Knowledge	Skills / Attitudes	Learning	Assessment
Acute coronary syndromes	Understand stable and unstable angina and myocardial infarction. (ACS) Pathophysiology of STEMI/non STEMI. Recognise ECG changes related to ACS, including right ventricular infarct and posterior infarct. Indications, contraindications and complications of thrombolysis. Adjunctive treatments. Indications for interventional cardiology. Causes of ST elevation in the absence of myocardial infarction. Management of left ventricular failure in the setting of myocardial infarction. Management of cardiogenic shock Pharmacology of cardiac drugs.	Recognise the need for urgent assessment and prompt treatment with thrombolysis when indicated. To be able to obtain assent for thrombolysis. To identify and treat complications such as arrhythmias, pulmonary oedema and hypotension.	LP LT GT PS LS ODA ODB	OC MC CBD AUD ME FCEM MCEM

in the Emergency Department

Central Manchester and Manchester Children's University Hospitals NHS Trust

CDSG 2003-01

Cardiac Chest Pain

Reason for this Guideline

Cardiac chest pain is probably the most frequent serious presentation to Emergency Departments in the UK. At MRI some 3% of new attendances will be covered by this label - with final diagnoses ranging from Acute Myocardial Infarction (AMI) requiring immediate revascularisation to musculoskeletal pain and shingles. While the recognition of ST elevated MI is fairly easy, the risk stratification of patients into those with high risk chest pain (sometimes referred to as` Acute Coronary Syndrome or unstable angina) who have a similar 30-day mortality to those with AMI, and those with low and moderate risk pain is difficult. Furthermore the selection of appropriate diagnostic and management strategies also presents considerable challenges. This guideline is designed to help the clinician through this process and ensures that appropriate risk management tools, diagnostic approaches and therapeutic interventions are effected.

Special points of interest:

- Cardiac Chest Pain is a common presentation accounting for some 3% of new attenders
- STEMI patients need emergency revasculari-sation
- The MCCPS criteria are used for further risk assessment
- High risk patients need LMWHs, clopidogrel, beta blockers and ad-mission
- Low risk patients need an appropriate rule-out (CPAU) strategy

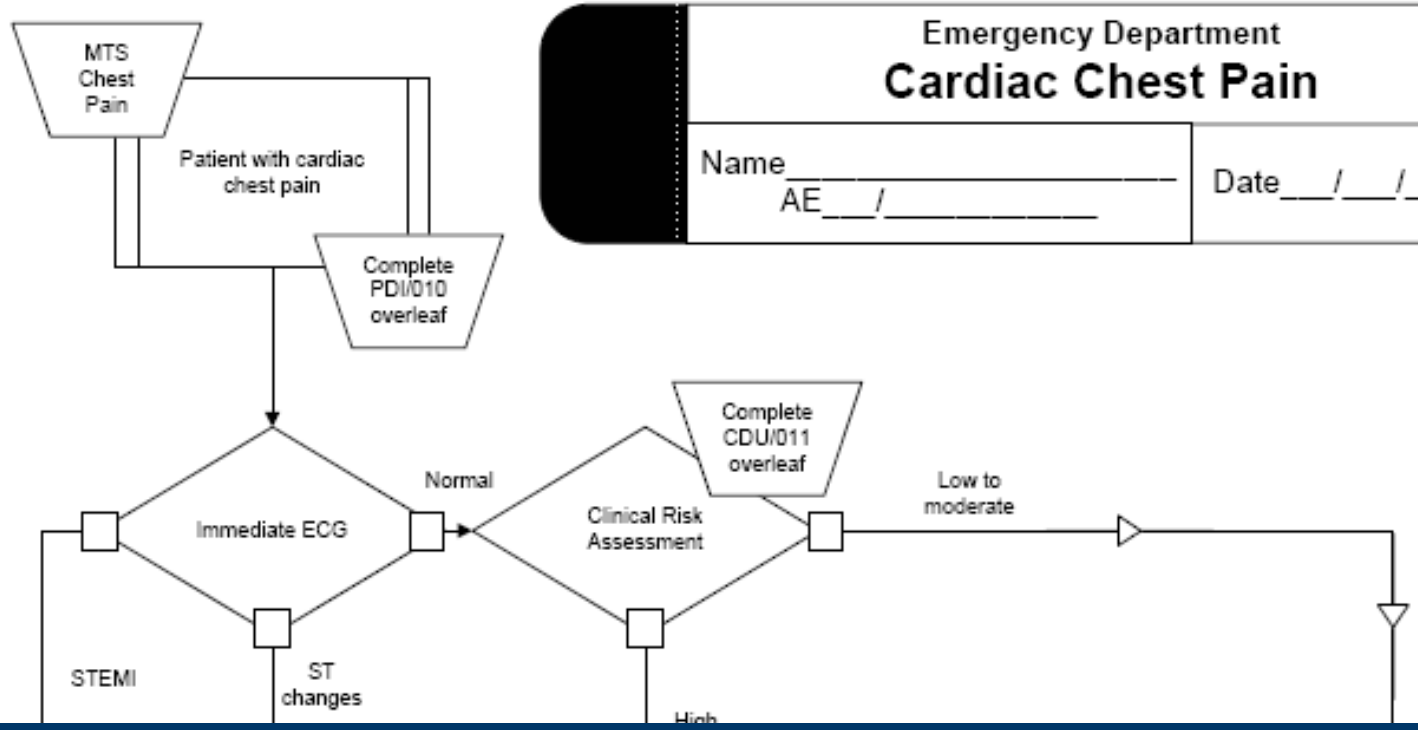
Emergency Department

Cardiac Chest Pain

Name_____

AE___/_____

Date___/___/_____



Fatal mistake prompts call for watchdog

A JUNIOR doctors' leader has called for a New Deal watchdog for Scotland after a mistake by an overworked house officer ended in the death of a patient.

Paracetamol overdose victim Margaret Barr died at Edinburgh Royal Infirmary after a junior doctor misread her dose as 24mg per litre of blood — a tenth of the actual.

In a fatal accident inquiry report, sheriff Alexander Wilkinson blamed the death on understaffing.

Since the accident last year the trust has taken on one more consultant and two extra house officers but Mr Nizam Mamode, deputy chairman of the Scottish Junior Doctors Committee, branded the move 'too little too late'.

'Eighty per cent of juniors at the Infirmary are still working outside the New Deal but this hospital is not alone,' he said.

'There are no task forces in Scotland but unless we have an independent body to take problems about hospitals to, these accidents will continue.'

Sheriff Wilkinson criticised the trust's manning levels. 'The routine medical work of the ward was in the hands of one junior house officer. He was inevitably placed under very considerable stress,' he said.

The College of Emergency Medicine

Patron: HRH The Princess Royal

7-9 Breams Buildings
London
EC4A 1DT

Tel +44 (0)207 404 1999
Fax +44 (0)207 067 1267
www.collemergencymed.ac.uk

3rd September 2012

Dear Colleagues,

Paracetamol overdose: new guidance on the use of intravenous acetylcysteine

The College Clinical Effectiveness Committee (CEC) has been working closely with the Medicines & Healthcare Products Regulatory Agency (MHRA) following a review by the Commission on Human Medicines of the treatment of paracetamol poisoning. Professor Simon Thomas chaired the implementation group, with input from the National Poisons Information Service (NPIS).

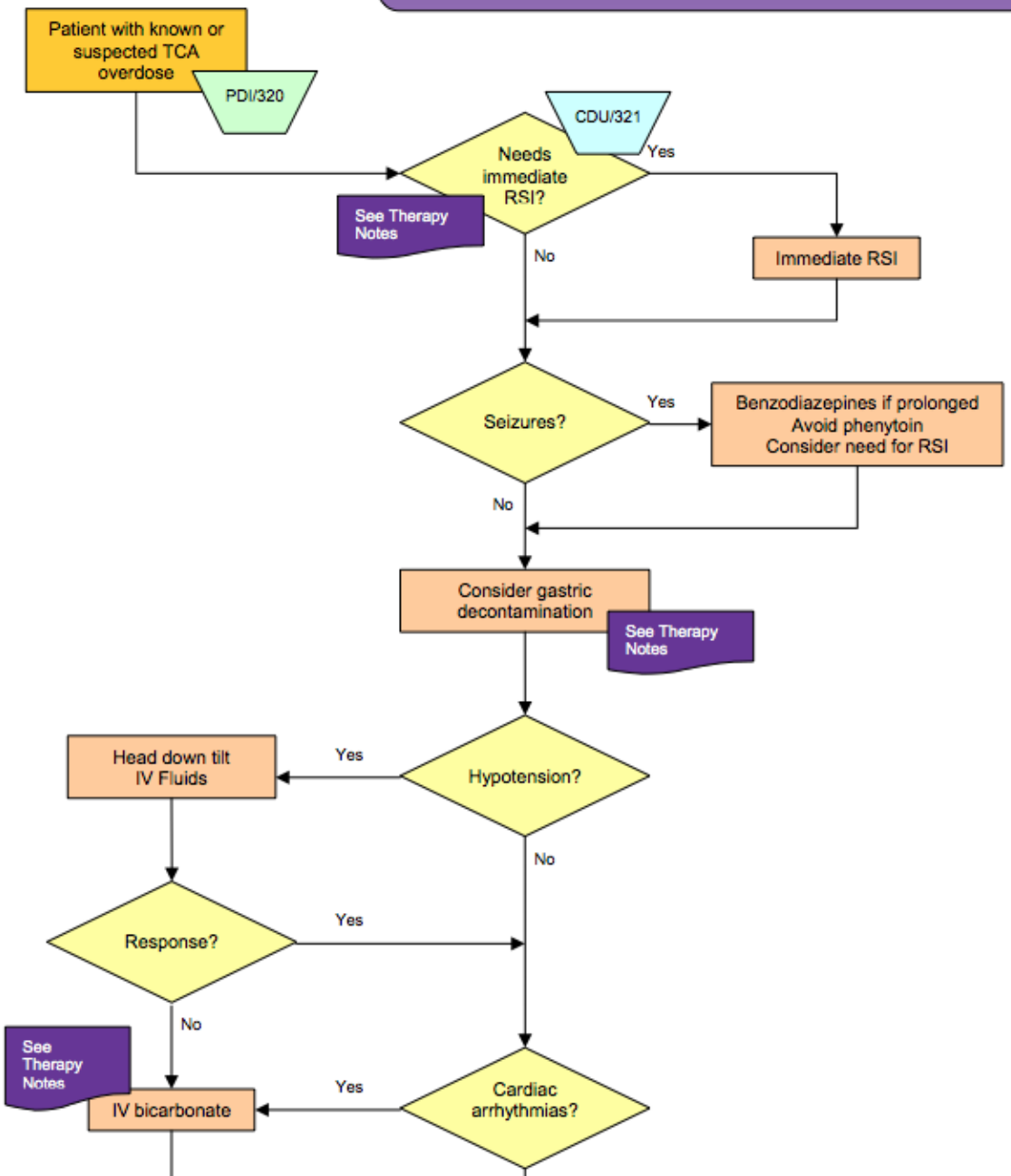
The key changes from previous guidance are:

- A single treatment line regardless of hepatotoxicity risk (see Annex I, below).
- The duration of administration of the first dose of intravenous acetylcysteine is increased from 15 minutes to 1 hour.
- Removal of hypersensitivity as a contraindication to treatment with acetylcysteine.
- Provision of weight-based dosing tables for adults and children.
- A Technical Information Leaflet (TIL) which gives more detailed instructions on the preparation of acetylcysteine infusions (see Annex II, below).

Poisoning

	The trainee will be able to assess promptly a patient presenting with deliberate or accidental poisoning, initiate urgent treatment, ensure appropriate monitoring and recognise the importance of psychiatric assessment in episodes of self harm		
	Knowledge	**Skills**	**Attitudes and Behaviour**
Competency Level 1	Recall indications for gastric lavage, activated charcoal and whole bowel irrigation Define parameters used to give clues to type of poisoning: pupils, pulse and respiration, blood pressure, temperature, glucose, seizure, coma, renal function, osmolar and anion gap Outline presentation and management of poisoning with: paracetamol, aspirin, opiates, alcohol, benzodiazepines, beta blockers, digoxin, carbon monoxide, anti-coagulants, tricyclics, SSRIs, amphetamines and cocaine Recognise importance of accessing TOXBASE and National Poisons Information Service	Recognise critically ill overdose patient and resuscitate as appropriate Take a full history of event, including collateral if possible Examine to determine nature and effects of poisoning Commence poison-specific treatments Order, interpret and act on initial investigations appropriately: biochemistry, arterial blood gas, glucose, ECG, and drug concentrations Ensure appropriate monitoring in acute period of care	Contact senior promptly in event of critical illness or patient refusing treatment Recognise the details of poisoning event given by patient may be inaccurate Show compassion and patience in the assessment and management of those who have self-harmed

Evidence-based flowchart for the Management of Tricyclic Antidepressant Overdose



CDU/321: NEED FOR IMMEDIATE RSI (ANY YES)

Airway compromise	Yes
Inadequate respiration (bradypnoea, hypoxia, significant hypercapnia)	Yes
GCS ≤8/15	Yes
Unmanageable agitation	Yes

CDU/322: DISPOSITION RISK ASSESSMENT
(HIGH IF ANY H, LOW IF ALL L AND NO H, OTHERWISE MODERATE)

Indications for RSI present	HIGH	
Persistent hypotension or inotrope/vasopressor support required	HIGH	
GCS <14/15	HIGH	
Cardiac arrhythmias	HIGH	
Alert (GCS 15/15)		LOW
Normal ECG (including QRS width <0.10s and no right axis deviation)		LOW
Normal heart rate (60-100bpm)		LOW
Systolic blood pressure ≥100mmHg		LOW
>2 hours since ingestion		LOW

Public Health England

1

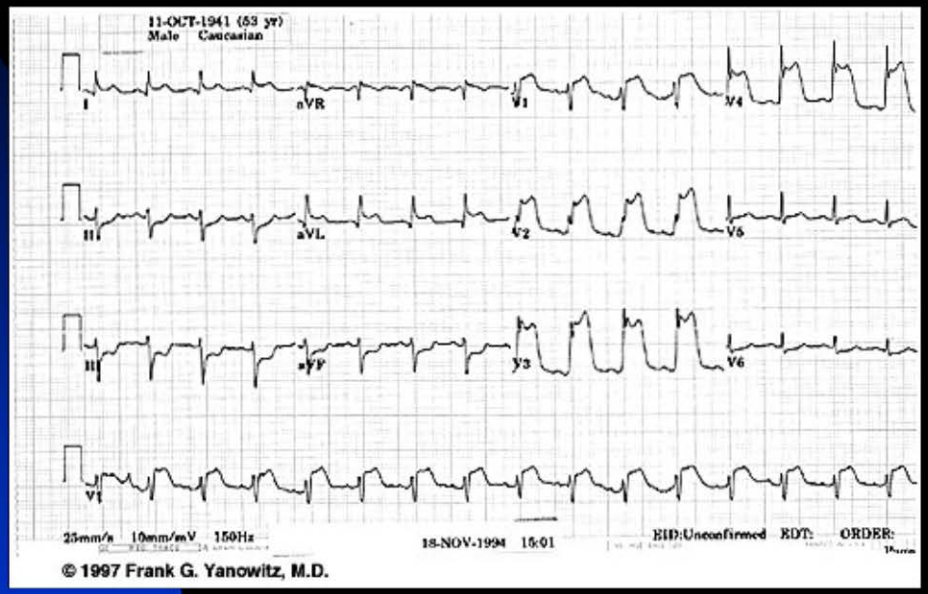
2

r GP for follow-up. Note this advice in discharge letter. 3

If the patient does not improve
Contact the NPIS for advice.
Contact your local HPT for advice.
Reconsider diagnosis.

4

See over for notes on boxes 1–4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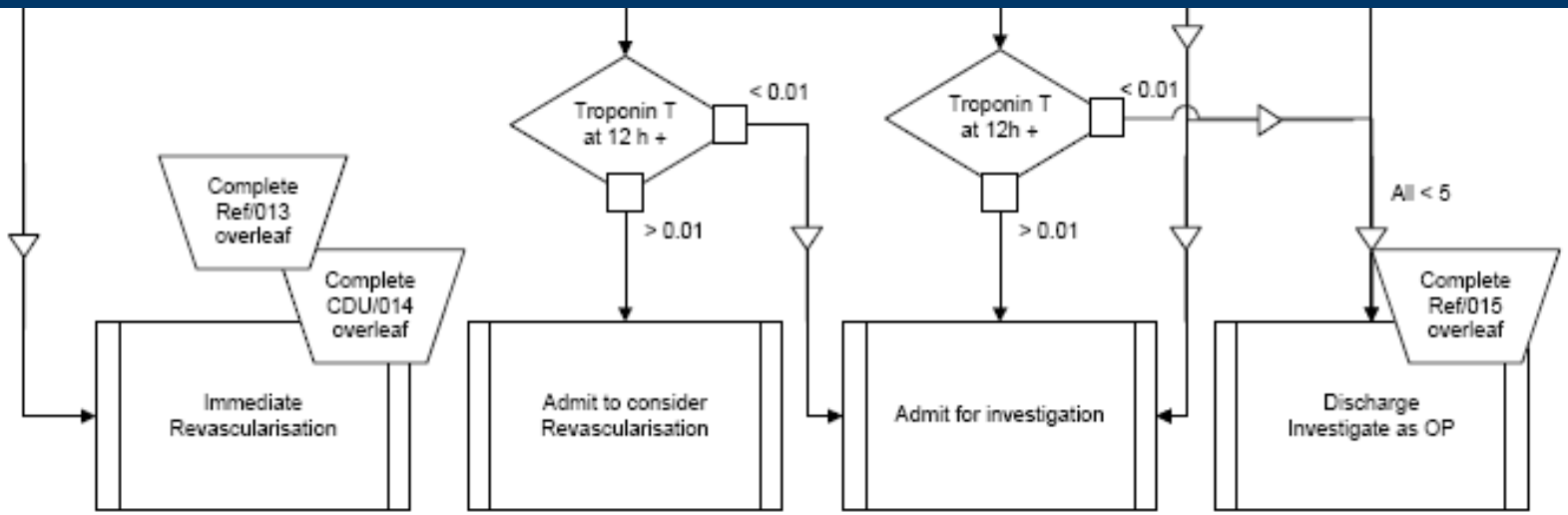
EID:Unconfirmed RDT: ORDER:
© 1997 Frank G. Yanowitz, M.D.

Pitfall

Exclusion of cardiac ischaemia based on reproducible chest wall tenderness

KEY FACT

7% of patient with acute MI or unstable angina had their pain partially or fully reproduced on chest wall palpation.


Troponin T
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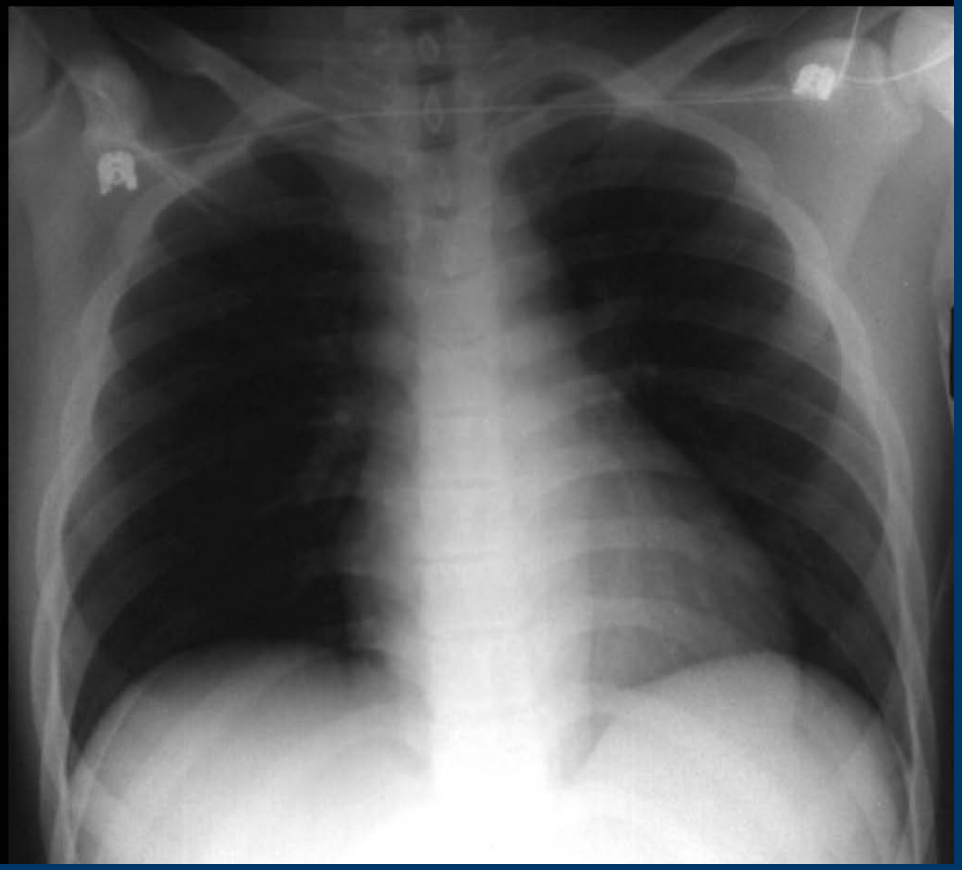
overleaf
Immediate
Revascularisation
Admit to consider
Revascularisation
Admit for investigation
Discharge
Investigate as OP

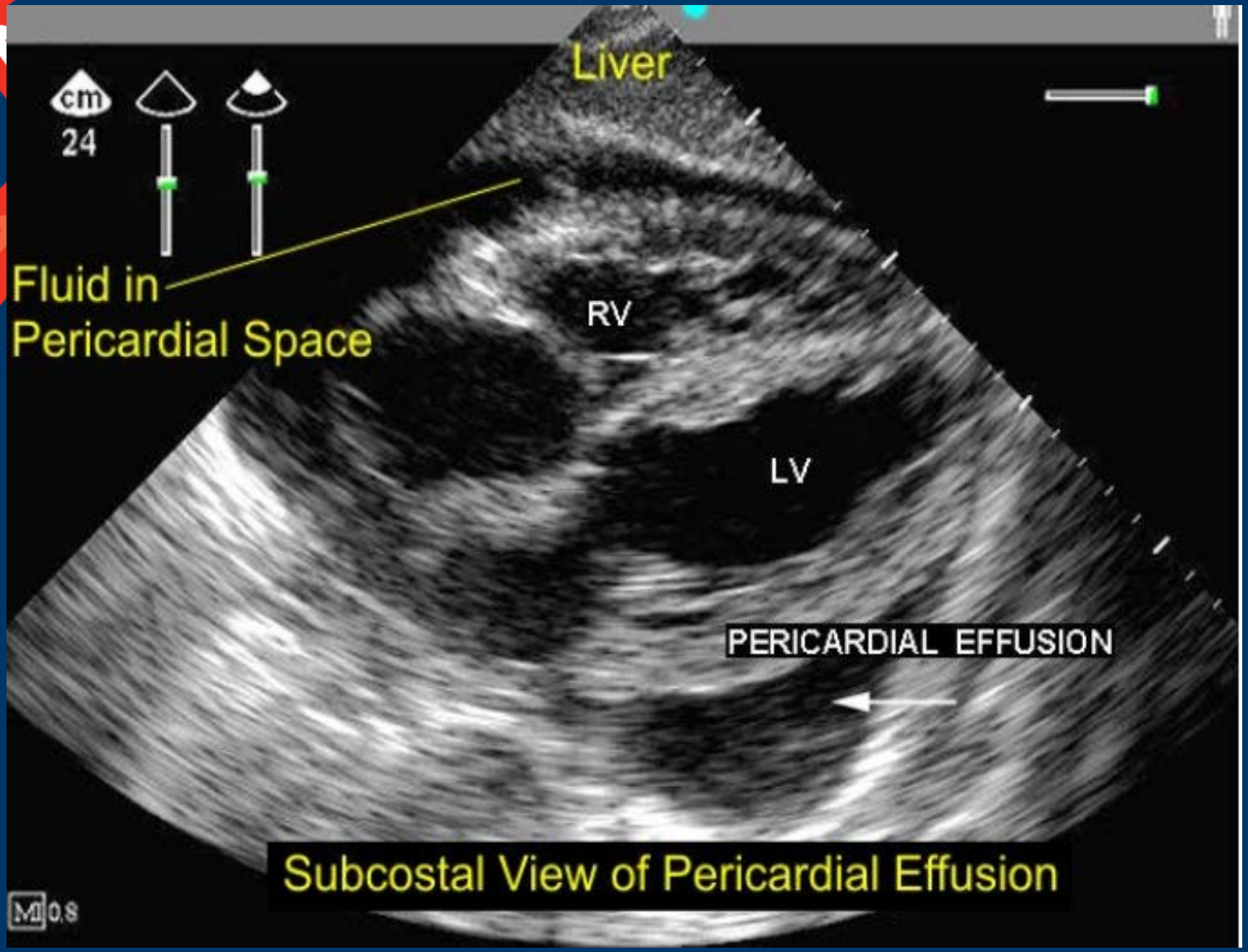
Risk Stratification

Chest pain

Prior Exercise test

9 year old child with chest pain attends Emergency department.

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cm
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Fluid in
Pericardial Space
RV
LV
PERICARDIAL EFFUSION
Subcostal View of Pericardial Effusion
M 0.8

Watch us at www.thinkFAST.org.uk

Chest
Heart &
Stroke
Scotland

If you see these signs
call 999 FAST.

ROSIER Scale
Stroke Assessment

The aim of this assessment tool is to enable medical and nursing staff to differentiate patients with stroke and stroke mimics.

Assessment Date ☐☐☐☐☐☐ Time ☐☐☐☐

Symptom onset Date ☐☐☐☐☐☐ Time ☐☐☐☐

GGS E=☐ M=☐ V=☐ **BP** ☐☐☐ ☐☐☐ ***BM** ☐☐☐☐

**** If BM < 3.5 mmol/l treat urgently and reassess once blood glucose normal***

Has there been loss of consciousness or syncope?

Y (-1) ☐ N (0) ☐

Has there been seizure activity?

Y (-1) ☐ N (0) ☐

Is there a NEW ACUTE onset (or on awakening from sleep)?

I.	Asymmetric facial weakness	Y (+1) ☐	N (0) ☐
II.	Asymmetric arm weakness	Y (+1) ☐	N (0) ☐
III.	Asymmetric leg weakness	Y (+1) ☐	N (0) ☐
IV.	Speech disturbance	Y (+1) ☐	N (0) ☐
V.	Visual field defect	Y (+1) ☐	N (0) ☐

*Total Score ____ (-2 to +5)

Provisional diagnosis: ☐ Stroke ☐ Non-stroke (specify) _____

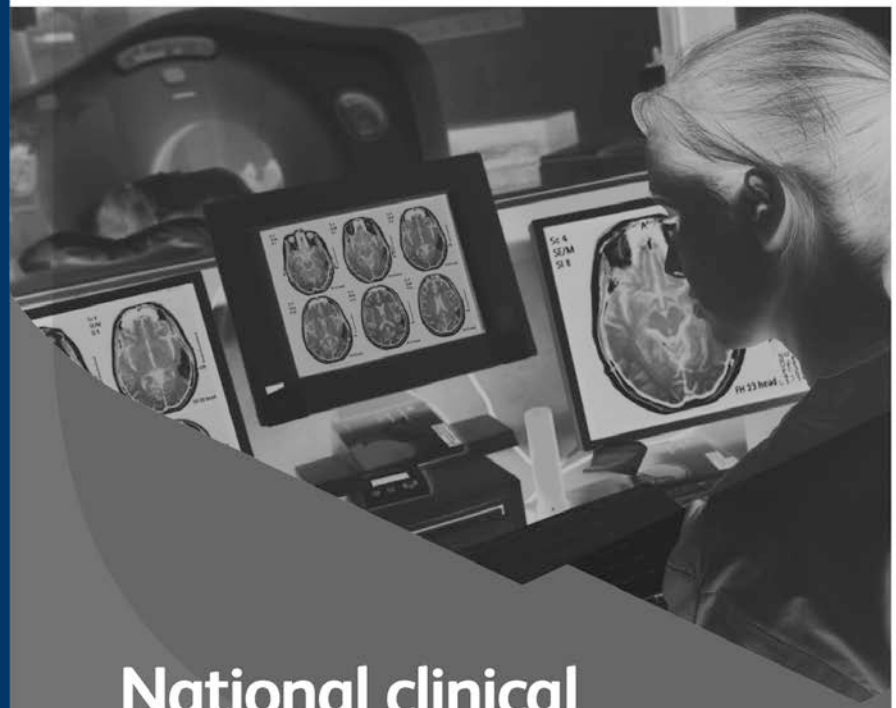
* Stroke is likely if total scores are > 0. Scores of </= 0 have a low possibility of stroke but not completely excluded.

A&E / EAU Stroke Instrument Guidelines

1. If total score > 0 (1 to 6) a diagnosis of acute stroke is likely. If total scores 0, -1 or -2 stroke unlikely but is not excluded and patient should be discussed with the stroke team. DECT phone 21616 – Stroke Specialist Nurse 9-5. Medical SpR – Out of hours.
2. All patients admitted with a suspected stroke, irrespective of score should be admitted to the Emergency Admissions Unit (EAU) at the RVI. Patients with a score of 0, -1 or -2 should be admitted to the EAU at the RVI.
3. If symptom onset within 3 hours and score >0 contact acute stroke team IMMEDIATELY for potential thrombolysis treatment and arrange urgent CT scan. Monday to Friday discuss with Stroke SpR or Consultant. Out of hours contact on call Stroke Consultant.

PTO

Royal College of Physicians



National clinical guideline for stroke

Prepared by the Intercollegiate Stroke Working Party

Fourth edition 2012

TIME TO ACT –Severe sepsis: rapid diagnosis and treatment saves lives

Care failings seem to occur mainly in the first few hours when rapid diagnosis and simple treatment can be critical to the chances of survival.

The shortcomings identified cover both the delivery of clinical care and the way it is organised.

Analysis

Summary of shortcomings

In the ten case stories described in this report, the shortcomings, compared with the applicable standards, are:

Standard	Number at variance
Clinical care	
Timely history and examination on admission or referral.	6
Investigations to determine:	7
• Indices of perfusion	5
• Indices of infection	4
• Source of infection	6
• Cultures of blood and other sites.	5
Regular physiological monitoring using track and trigger systems.	3
Accurate recognition of severity of the illness.	7
Basic resuscitation with:	8
• Large-volume fluid therapy	7
• Intravenous broad-spectrum antibiotics after taking cultures	7
• Vasopressor therapy if required to maintain adequate haemodynamics and tissue perfusion.	5
All of these actions to commence immediately on recognition of severe sepsis and to be completed within six hours.	5
Source control to be performed as soon as possible after initial fluid resuscitation.	4

In addition to these recommendations, the College has had further discussions on how we can act upon the findings of the audit:

Action 1
A fresh national awareness campaign on the importance of early diagnosis and treatment across the specialty before the repeat audit.

Action 2
Communication with chief executives, trust boards and emerging clinical commissioning groups to make them aware and encourage support.

Action 3
Early intervention of senior staff and extending the hours, especially in the evenings and weekends, where consultants are on the 'shop floor', which will require recruiting more consultants in some hospitals.

Action 4
Renewed emphasis and frequency of training for nursing and medical staff in departmental and specialist training programmes.

Action 5
Engaging more with nursing staff so that the departmental care pathways are jointly prepared and implemented.

Action 6
Ensuring all emergency departments have a blood gas machine in the department that can measure lactate, so that results are available in minutes.

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The reassurance from the fact that Child B's temperature fell after paracetamol was given, was also misplaced.

What happened next

At our recommendation, the Trust apologised to Child B's family, paid them compensation and explained how they would prevent a repeat of their failings. Specific measures put in place by the Trust include developing a paediatric early warning score system, and preparing local clinical guidelines on the clinical management of children with fever. We also recommended that the registrar reflected on our findings and worked with her local clinical tutor to agree and implement a plan to address the specific failings in her care of Child B.

The hospital has since admitted breaches in the duty of care provided to Child B.

'Now we are left with the unbearable pain of losing her. Our home is too quiet, empty, and our happy lives together have been shattered.'

The family of Child B

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Appendix 3 - Evidence from the College of Emergency Medicine

The following is evidence given to us by the College of Emergency Medicine.

Introduction

The College was aware of the launch of the Surviving Sepsis Campaign and fully supported it, because the potential reduction in death, suffering and disability for patients is enormous. In 2008 an expert panel, including emergency physicians, consultants in intensive care and nurse consultants met on several occasions to develop a set of clinical standards, which were published and distributed to all consultants and emergency departments in May 2009. This is one of several initiatives the Clinical Effectiveness Committee is currently taking to focus on quality care and safety for sick patients presenting to emergency departments.

Following publication of these standards, one year was allowed for the implementation of these changes and the introduction of a care pathway for this important group of patients. This was followed in 2011 by a national audit against the College's standards. 160 emergency departments (74%) participated and it was completed on 31 January 2012. On 18 May 2012 each participating trust was sent an individualised report containing their audit result, and direct comparisons with national results, so their performance could be clearly seen.

This audit covered key areas of quality of care:

- Recording of vital signs on arrival (temperature, pulse, blood pressure, and so on).
- Oxygen delivery on arrival.
- Taking of important blood tests, including culture for bacteria in the blood.
- Timely administration of powerful antibiotics.
- Starting intravenous fluids to restore or maintain blood pressure.
- Measuring the amount of urine to monitor response to treatment.

A detailed report with full findings is available at the College of Emergency Medicine website.

www.collemergencymed.ac.uk

In summary, the results of the audit indicated that approximately 80% of patients receive good quality care, but that in the remaining 20% care is substandard. We are also aware, from previous smaller departmental audits and from the literature, that there are occasional catastrophes both within emergency departments and in hospital. This is a condition that can and does occur on the wards and is not exclusively an emergency

Casebook

Cauda equina syndrome

PLUS:
The role of the expert witness
Case reports

Box 1. What is Cauda Equina Syndrome?

CES is a collection of signs and symptoms resulting from compression of the bundle of nerve roots emerging from the end of the spinal cord below the 1st lumbar vertebra. The classic syndrome is characterised by severe LBP with bilateral sciatica associated with saddle anaesthesia, urinary retention and bowel dysfunction.

Causes of CES

- Traumatic injury
- Herniated intervertebral disc
- Secondary to surgery, spinal or epidural anaesthesia, spinal manipulation
- Tumours
- Infections
- Vascular problems
- Spina bifida
- Spinal stenosis
- Late-stage ankylosing spondylitis.

Box 2. Red flags

Severe low back pain with bilateral or unilateral sciatica

Bladder or bowel dysfunction

Anaesthesia or paresthesia in perineal region or buttocks

Significant lower limb weakness

Gait disturbances

Sexual dysfunction

Continued from page 11

his buttocks and lower limbs restricted his

Box 3. Types of onset

The onset of CES can be either acute or chronic. These are characterised by:

Group I (30% of patients[13]):
Acute onset of severe back pain, sciatica, urinary disturbances, motor weakness in the lower extremities and saddle anaesthesia or hypoesthesia in patient with no previous history of LBP.[8]

Group II (70% of patients[13]):
More insidious onset 'characterised by recurrent episodes of backache over periods ranging from a few weeks to years and then the gradual onset of sciatica and motor and sensory loss, with bowel and bladder dysfunction developing over time intervals that range from a few days to several weeks.'[8]

Box 4. Four vital questions to ask patients presenting with LBP

'Have you noticed any numbness or strange sensations around your buttocks or between your legs? For example, does the toilet paper feel normal when you wipe your bottom?'

'Has your bladder been working normally? Can you tell when it's full? Have you had any loss of control (accidents), or difficulty passing urine? Or have you felt that you want to go all the time?'

'Have you experienced any unusual problems with your bowels lately?'

'Have you noticed any changes in sexual function, like loss of feeling in your genitals or not being able to get an erection or ejaculate?'

The questions and the patient's response should be clearly documented in the medical record. This is necessary, not only from a medico-legal viewpoint, but because it will assist practitioners in recognising changes when neurological symptoms emerge progressively.

necessarily a correlation between timing of surgery and the prospects of recovery.

The other expert lent only limited support to this view.

The claimant's experts argued that, as Mr Rosamond's symptoms had emerged progressively, the delay in treatment had a bearing on the severity of the trauma and the eventual outcome. The motor nerves in

Conclusion

Cauda equina syndrome is a rare condition, but its effects are serious, leading to profound physical and social disabilities. Although there is debate about the efficacy of timely surgical decompression, it is commonly accepted that early intervention is advisable, the optimum time being within 48 hours of the onset of definitive symptoms. Claims relating to cauda equina syndrome

Questions