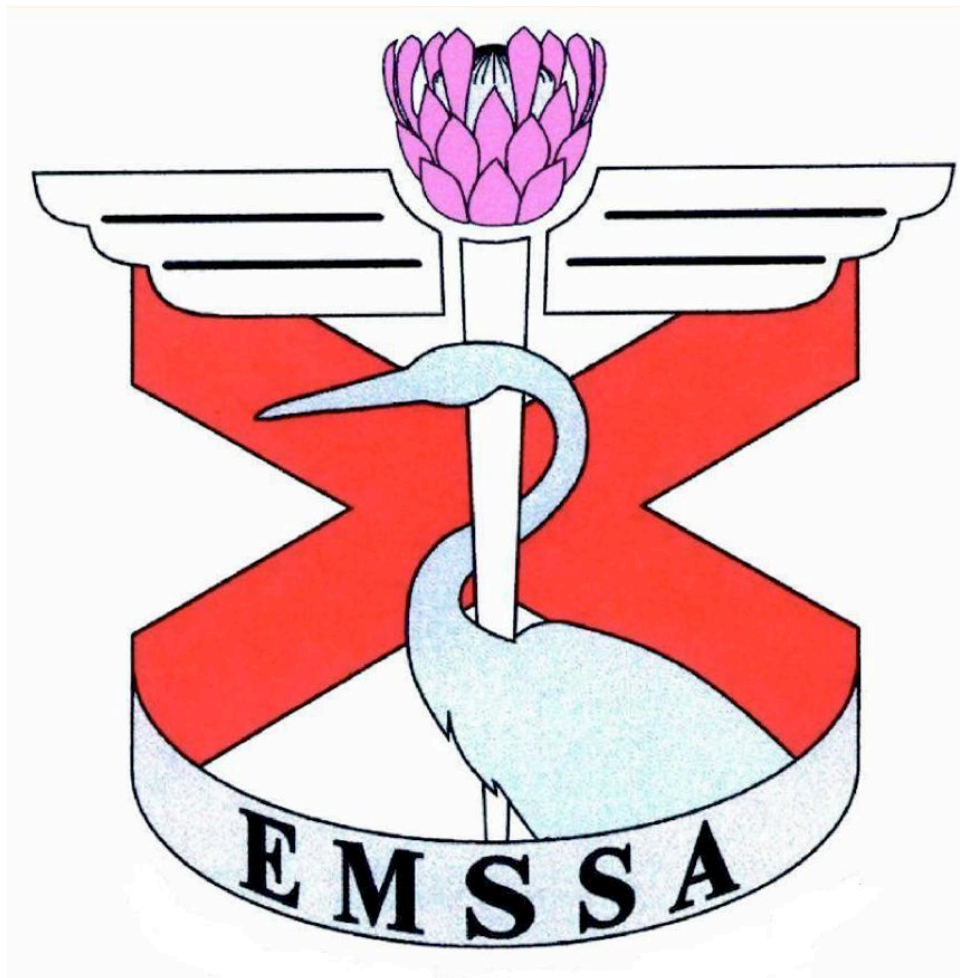


Newsletter

August 2010

Healthcare professionals dedicated to the development of quality emergency care
throughout South Africa



EDITORIAL

Hi Everyone

Welcome to the second newsletter of 2010. The FIFA World Cup Soccer Tournament has finally come to an end. What an amazing time for South Africa! The lack of any significant major incidents is a testimony to the extensive planning and hard work that went on for the past few years. This behind the scenes preparation has resulted in the formation of strong interdisciplinary links which will now continue into the future. The legacy of this tournament is going to affect almost every aspect of South African life. All the emergency care personnel involved from the Fan Parks, Public viewing areas and stadiums to the definitive care facilities need to be commended on a job well done. This is a reflection on the excellence and high standard of emergency care that is being delivered in South Africa. Let us all strive to improve standards and access to emergency care in this country.

In this month's newsletter, Martin Botha provides us with a comprehensive update on the Resuscitation Council of South Africa. EMSSA would like to take this opportunity to congratulate the RCSA on 21 years of exceptional training and research into the practice of resuscitative care in South Africa.

Our anonymous blogger makes comments on the recent World Cup from an emergency medicine perspective and we have a new ENSSA blog starting this month.

There are no further CME days planned for this year but watch the website because we will be holding regional CME days next year. These events have proven to be of a very high academic standard and extremely popular.

Up to eight new practice guidelines are in the process of being published on the website or in the developmental phase. Keep checking the website for the latest downloads.

Please remember to register for the EMSSA Symposium, which is being held from 20 – 21 November 2010 in Cape Town at the Leslie Building, Upper Campus, UCT. The new ILCOR

Resuscitation guidelines will be presented and discussed as well as Patient Safety in Emergency Care. A level 1 emergency point of care ultrasound course will be held on 19 November 2010. Find further details at www.emssa2010.co.za

Once again please contact me with feedback about the new look newsletter. Let us know of any specific content that you would like to see added.

Until the next issue...

Melanie Stander



EMERGENCY MEDICINE SYMPOSIUM

An exciting upcoming event is the 2010 EMSSA Symposium which will be held from November 20th to 21st in Cape Town and will be of interest to all levels of staff involved in the emergency care of patients.

The two themes for this symposium will be Patient Safety in Emergency Care and the 2010 ILCOR Resuscitation Guidelines. Emergency care often involves managing patients with rapidly evolving conditions in poorly controlled environments. All manner of Patient-Safety factors can impact on the outcome for an individual patient - whether it is delayed pre-hospital care; long waiting times in Emergency Centres or sub-optimal care as a result of staff or equipment shortages. We are very fortunate to have some of the world's leading experts on Patient Safety - Professor Pat Croskerry and Professor Terry Mulligan speaking at the symposium. Topics covered will include: emergency centre design and management; adverse events in emergency care and how to minimise them; systems to help relieve emergency centre overcrowding; safe discharge and transfer of patients and the effects of shiftwork on performance and how to make more tolerable rosters.

The symposium will also be the first national discussion forum for the 2010 ILCOR Resuscitation Guidelines. Eminent experts and members of the SA Resuscitation Council - Mr Martin Botha and Drs Walter Kloock, Ashraf Coovadia and Sithembiso Velaphi - will give updates on the latest resuscitation advice for Basic and Advanced Life Support and special circumstances, as well as Paediatric and Neonatal Life Support. There will be an Expert Panel Question & Answer Session on the new resuscitation guidelines. In addition there will be abstract presentations of original research relevant to the field of emergency care in South Africa. For further details of the conference please see: www.emssa2010.co.za

The Resuscitation Council of Southern Africa

Aim: The Resuscitation Council of Southern Africa (RCSA) is a voluntary co-ordinating body whose primary aim is to foster and co-ordinate the practice and teaching of resuscitation, and to promote uniformity and standardization of resuscitation techniques.

Objectives:

To gather and collate as much scientific information regarding resuscitation techniques from as wide a variety of sources as possible, and to disseminate this information to all interested parties.

To provide an advisory and resource service regarding techniques, equipment, teaching methods and teaching aids.

To foster research into methods of practice and teaching of resuscitation.

To establish regular communications with other bodies with similar objectives, both in Southern Africa and abroad, and to provide a forum for discussion of all aspects of resuscitation.

Simply then the RCSA exists to deliver quality resuscitation training and also to support a dynamic and expanding network of instructors and TC network.

We strive toward a situation where **everyone in our country is competent to do CPR and use an AED**. The RCSA has begun to lobby key stakeholders, to enhance community, government and public engagement on resuscitation matters, and to advocate for widespread awareness and training campaigns for CPR and emergency cardiovascular care. We must passionately call for all Health Care Providers to be BLS, ACLS and PALS trained. Our initial passion all those years ago was to teach the population CPR and the use of an AED, and to avidly create awareness around these... we must persist and not lose that initial focus.

The RCSA is proud to have been involved in the evidence-based consensus on science process, having produced 3 worksheets in the current ILCOR evidence review. The RCSA must be recognised as the benchmark, indeed *THE* brand and quality mark of excellence in resuscitation

training and systems. We will continue to develop and promote evidence-based standards & guidelines, while pursuing interaction and interdependence with affiliates. This all needs to be inclusive, accessible, academically and operationally relevant and credible, and indeed affordable to all.

Celebrating 21 years!

The phoenix has recently been adopted as the logo for the newly launched RCSA newsletter. Here's the background to the legend:

The ancient myth of the Phoenix speaks to the themes of renewal and rebirth. The flying flames of the phoenix are a metaphor for the Sun, the spark of life, something essential for existence, which dies at night and is reborn in morning. Early Christian tradition adopted the phoenix as a symbol of both immortality & resurrection.

As the legend goes, the phoenix is able to reproduce itself. It lives on frankincense and odoriferous gums and when it has lived 500 years, it builds itself a nest in the branches of an oak, or atop a palm tree, and here collects cinnamon, spikenard and myrrh, and of with these builds a pile on which it lies to die, breathing out its last breath amidst these odours. From the body of the parent bird, a young phoenix rises.

Thus, according to legend, the phoenix consumed itself by fire every 500 years, and a new, young phoenix sprang from its ashes.

That is a fitting metaphor for resuscitation! It's about reanimation and renewal. We teach people to resuscitate and thus to offer a chance of new life. That is both an awesome responsibility and indeed a privilege!

The RCSA has come of age...celebrating 21 proud years of activity in our region. I'm aware that we are not 500 years old, but celebrating 50 years of CPR, we can now stand on the shoulders of those giants before us and with gusto embrace the responsibility of taking the organisation to the next level. Everyone needs to consistently espouse the same message, and take up the cudgels: CPR saves lives... but only if you know how!

Martin Botha

Chairman: Resuscitation Council of SA

An article that appeared in the recent Resuscitation Council of SA newsletter:

Saved by an AED

Article by Gavin Mackintosh

"I consider myself a strong cyclist and at the time of this incident I was preparing for a multi-day mountain bike race in the Alps. Working long hours, travelling overseas, and still trying to fit in hard training time.

On 27 April 2008 I was participating in the Giants MTB race. I was riding with my wife. About 5km from the finish she needed to push harder if she was to maintain her overall position so we agreed (after a bit of an argument from her!) that she should continue on her own. Shortly after this about 2 km from the end, I suffered a heart attack.

A fellow competitor was nearby and saw me put down my bike and then lie down on it. Although he had no formal CPR training he knew he had to do chest compressions and breathe for me which he started probably in less than 1min of my collapse. A further 5 or so riders (including my wife) joined him taking turns at doing the chest compressions & breathing. The medical backup arrived within 5-10min and were top class in their knowledge, ability and equipment. It took between 30-40mins of CPR, several doses of adrenaline & about 3 jolts with the defibrillator to re-establish a normal heart rhythm. After they stabilised me, I was airlifted to the nearest hospital in Pietermaritzburg. The first memory I have after the incident was 8 days later in ICU.

If the paramedics did not have an AED I would not be alive to tell this story.

It made me aware that it is all very well to know how to carry out CPR but on occasions such as this where the heart is fibrillating, unless you have rapid access to an AED you will die.

Realising that there are many people who fall into the "high stress work category" who are members of Club 100 (my cycling club), I suggested to our

committee that the purchase of an AED would be worthwhile. Club 100 supports both road riding as well mountain biking so 2 units were purchased. The road riders generally have a motor vehicle for technical back-up, so the transport, size & weight of an AED are not an issue. For off-road riding there is no back-up, so the AED has to be compact and as lightweight as possible. The unit that the MTB ride master carries weighs less than 750g and is small enough to fit into a hydration pack.

I was unaware of my relatively high cholesterol level or the fact that it is genetic. It is also apparent that few people are aware of their status and believe "If you are fit you won't have high cholesterol, so there is no risk of a heart attack!!" I proved otherwise and am also proof of the invaluable role of CPR training and the use of an AED."

RESUSCITATION COUNCIL OF SOUTHERN AFRICA

RESPONSE TO DRAFT BY-LAWS FOR THE SAFE GUARDING OF SWIMMING POOLS

In a letter sent to the City of Johannesburg Metropolitan Municipality, the RCSA was delighted to note the planned by-laws for the safe guarding of swimming pools in Johannesburg. It strongly endorses the proposal in principle, and would actively support any initiative attempting to reduce deaths from drowning.

Furthermore the RCSA recommended that all swimming pool owners and every adult resident on the premises should be currently certified in cardio-pulmonary resuscitation (CPR). This should be mandatory where children and non-swimming adults have access to that swimming pool. Besides being CPR trained, pool owners ought to prominently display a laminated CPR chart on the swimming pool fence, as has already been benchmarked via legislation in parts of Australia.

The EXCO of the RCSA encouraged the City of Jhb Metro to urgently implement these by-laws, which

would undoubtedly save many innocent lives. Deaths from drowning are preventable, and early awareness is the very first and most effective way of influencing survival. We applaud the City of Johannesburg in addressing this issue and will take up the cudgels to bolster your bid to compel pool owners to be more responsible and proactive in preventing drowning deaths. *Child safety is indeed no accident!*

Resuscitation Council of SA Professional Membership

In addition to all registered RCSA instructors, new membership categories have been instituted in line with our vision to develop and affiliate with more individuals and organisations.

Any health care professional (who is not already an registered instructor with the RCSA):

who attends and completes any official RCSA course, and who wants to support the RCSA & endorse

their vision and objectives, & is committed to strengthening the chain of survival in their community,

Is invited to become a

PROFESSIONAL MEMBER of the RCSA,

& in so doing, affiliate with the RCSA,

which is celebrating its 21st anniversary!

RCSA Professional Membership benefits include:

Membership fee of only R150 per year,

RCSA Professional Membership card,

Countless networking opportunities with like-minded professionals,

RCSA quarterly newsletter,

Opportunity to participate in mentoring programs.

Save 20% on RCSA CPD offerings and updates / symposiums,

Save 15% on access to MELISA – the Medical Electronic Library of SA,

plus get links to valuable resources;

Save by having access to special discounts from certain emergency equipment suppliers.

Completed Membership application forms and proof of payment

can be sent to Lorraine: 086-607-3930, or e-mail to: lorraine@resus.co.za

Professional Membership applications are posted on our website: www.resuscitationcouncil.co.za

EMERGENCY CARE PRACTITIONER INCREASED SCOPE OF PRACTISE

The recently promulgated Emergency Care Practitioner (ECP) scope of practise published by the HPCSA Professional Board for Emergency Care now includes out-of-hospital RSI (rapid sequence intubation) and fibrinolysis for STEMI. These interventions are directed by detailed protocols and are predicated on apposite clinical governance, with appropriate equipment, and a system allowing for analysis of data and evaluation of practice. Operationalising this effectively and safely must be systems-based, with strong prospective, ongoing, and retrospective supervision essential to ensure high procedure success rates. Each emergency medical service should institute a robust clinical governance structure that includes audit, quality improvement, self-regulation, reflection, tracking of data and performance.

The debate around whether out-of-hospital (OOH) RSI is appropriate continues. The most recent position statement released by the National Association of Emergency Physicians (NAEMSP) in the USA declares that OOH RSI should be employed only by EMS systems that specifically require the procedure and have adequate resources to develop, maintain and audit this protocol.

The trend evident from the literature appears not to dispute the tracheal intubation per se, but rather how it is performed. The gold standard of advanced airway management remains ETI and the patient, whether in-hospital or out, it can be

argued deserves the same level of competent care. It is imperative that the skill is performed safely and in line with international best-practice, to protect the patient from harm and indeed the practitioner from liability.

PREPARING YOUR EMERGENCY DEPARTMENT TO MANAGE THE SUDDEN DEATH OF A PATIENT

Dr Petra Brysiewicz, President: Emergency Nurses Society of South Africa, School of Nursing, University of KwaZulu-Natal

Introduction

The environment of the Emergency Department (ED) is unique and this makes incorporating palliative care into the ED difficult for a number of reasons. A sudden death is always a tragic occurrence which is very seldom peaceful or dignified. The care of a dying patient in the ED is not very clear and not much attention is paid to it as this is usually something to offer when all other measures have failed. The public value a death with dignity which is free of machines, equipment and various invasive life saving measures but they also value the high technology of emergency or critical care where dramatic interventions can save the life of the client (Mosenthal & Murphy, 2003).

The ED culture is geared towards caring for the physical rather than the psychological aspects of the client's care (Crowley, 2000) as the ED is an open, busy environment which is noisy and offers little privacy. Iserson (1999) states that the ED staff have limited time as they need to treat other patients and may often be interrupted to make other decisions, often concerning other clients. The backlog of clients who were neglected during the resuscitation of a critical client need to be attended to and thus the families of clients are often given little attention. Therapeutic management of the dead or dying client and their

bereaved family can also be extremely time-consuming.

An individual's behaviour is greatly influenced by one's beliefs and values, and health professionals need to acknowledge that they are unable to separate this from themselves when they are at work or, rather than they shouldn't be trying to do this. Death views are personal and reflect one's own experiences, religion and culture.

In order to ensure the therapeutic management of the sudden death of a patient in the ED it is important that the ED is prepared beforehand for this role (Brysiewicz & Uys, 2006). This preparation includes the following;

- Acknowledgement of the uniqueness of the ED environment by hospital management.
- The ED is an area where the health professionals are expected to deliver complex physiologic care and this includes performing a number of medical and technological procedures. Health professionals who practice in this way often view the family as an obstacle, and when staff exclude the family and give purely technological care, the results can be devastating as the families are neglected. Flam (1999) suggests that the health professionals should strive to have a "high touch" approach to managing sudden death in order to complement the already "high tech" care that is being given.
- Health professionals in the ED need to debate "witnessed resuscitation" – that is the process of actively resuscitating the patient in the presence of family members. Historically, the family was prevented from being present as health professionals felt it would be too traumatic for them to watch and that the family may get in the way and hamper any progress. There is research available on the positive effects that witnessed resuscitation has on the family and that it improves the ability of the bereaved to

cope with the grieving process after the loss of their loved one (Rattrie, 2000).

- Health professionals can ensure adequate resources for managing the sudden death in the ED by ensuring privacy for the families and obtaining and making available the necessary information (e.g. an information pamphlet for the families) and support for the families.
- Witnessing the trauma of others on a daily basis places the health professionals working in the ED at risk for developing various stress disorders. These professionals need to acknowledge that the work in the ED is difficult and that being exposed to sudden deaths in particular makes this environment even more difficult to cope with.
- Psychological support for the health professionals needs to be considered and made available to all the members of the health team. This support should be offered continuously and not only arranged when it becomes apparent that the staff need it.
- Doctors and nurses need to be supportive of each other and see themselves as complementary team members in the ED (Hojat, et al., 2003). It is also important that there is good communication between the ED health professionals and other members of the team e.g. transplant coordinators, mortuary staff, police etc.
- Attention needs to be given to new staff as they need to be supported and orientated in their role in the ED.

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EMSSA Blog

Is there life after the World Cup?

The World Cup is over. People are broke. Flags on cars and those weird mirror socks have been taken down. Now what? What possible reason do we still have to get up in the morning?

There is so much that we can learn from the World Cup. We've proven to the world, but more importantly to ourselves, that the mythical concept of customer service can be achieved. For the first time since maybe the Rugby World Cup in 1995, were we all proud to be South African. The general atmosphere was one of celebration. A month long party. What an amazing experience. We will all treasure the memories. We have to say well done and thank you to everyone behind the scenes that made this WC a memorable and safe one. To everyone in the health service, well done.

But after a month of positive daily news headlines, the status quo is returning. It disturbed this random doctor to see the return of the xenophobic hatred that plagued this country last year. This after everyone was singing, "Waka Waka it's time for Africa." Everyone was so proud to be African supporting all the African teams. Yet there were threats of violence against our fellow Africans. I refuse to give this kind of violence a special name like xenophobia. Let's call it what it is. Racism. Violence carried out by a handful of thugs.

Back to the things I learned from the WC. I was amazed by the acrobatics of soccer players. I'm not at all referring to the bicycle kicks or people soaring into the air to head the ball into the net. I'm talking about all the tumbling. It's the only sport where players don't just fall but continue to roll and hold onto either their leg or head, whether or not that was the injured body part. What was even stranger was that there was usually no one near them when said tumbling took place. My conclusions are: 1. someone strategically placed rocks on the pitch especially in the penalty box. 2. Their laces were loose (a problem I experience quite often) 3. The opposing team had invisible substitutes run onto the field and trip these players heading towards goal.

What also amazed me was the miraculous recovery these players made. One minute the player would be tumbling and holding onto either leg or head and pleading for someone to notice them. Much like an attention hungry 5 year old. Much like a 5 year old if no one paid attention to the tumbling player he immediately sulked a bit but continued playing with his friends.

I cannot talk about the WC without mentioning the vuvuzela. Whether you blew it to irritate others (you succeeded) or you were the person with ear plugs wishing to impale the user with the horn, the vuvu made an impact. I was thinking about alternative uses for the vuvu. A few possibilities: a vase, a beer funnel, hard collar for a giraffe, as an alternative to a defective siren on the ambulance of response vehicle (this actually happened to me). If you have any suggestions, please let me know.

What was interesting were the vuvu-related injuries. People smacked on the head with a wayward vuvu that was recklessly waved around during the "Wavin' flag" song. People were complaining about vuvu lips. I'm sure there is an ICD-10 code for it. Let's not forget the case of the woman who blew a hole in her throat due to poor technique. Amateurs!

But in the end a German octopus correctly predicted that Spain would prove everyone wrong and finally raise that Cup.

Well done, Spain. Well done, South Africa.

Email: randomdoctor@yahoo.com

ENSSA Blog

I was fortunate enough to be involved in providing emergency care at one of the FIFA soccer stadiums and I witnessed this historic event from across the road. I was extremely honoured and impressed to be a part of this emergency team which was made up of doctors, pre-hospital staff and a nurse (me) all working together to ensure high quality emergency care - which fortunately was never actually needed! Tell us how you as an emergency nurses were involved in the FIFA World Cup.

Thanks, Bye

P. Brysiewicz

Email: Brysiewicz@ukzn.ac.za



Calendar

November

1 - 3 November:

MIMMS

4 – 5 November:

HMIMMS

Cape Town

20 - 21 November:

EMERGENCY MEDICINE SYMPOSIUM

Cape Town

27 November:

LEVEL 2 ULTRASOUND COURSE

Johannesburg

Letters to the Editor

This is a call for all involved in emergency medicine, nursing and EMS to submit letters to the editor Email: melanie_stander@yahoo.co.uk

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1. Journal name:	Emergency Medicine Journal
Month:	July
1. Article title: (actual or revised)	Do emergency department attendances by homeless people increase in cold weather?
URL:	
Reference: (year, vol, page)	<i>Emerg Med J 2010;27:526-529</i>
Article summary:	<p>This retrospective review of admissions to Northern General Emergency Department in Sheffield from 2003 to 2008 evaluated whether homeless people attended the ED more frequently in winter to escape the weather. They found that of the 528 573 attendances in the 6 year period, 2930 (0.55%) were described as having no fixed abode. 63% of these arrived by ambulance. 17.4% left without being seen.</p> <p>Comment: There was no increase in attendance in cold weather. The authors suggest that this may be due to the increased number of shelters and other accommodation made available to the homeless in winter.</p>

2. Journal name:	Paediatric Emergency Care
Month:	July
1. Article title: (actual or revised)	Occult Pneumonia in Infants With High Fever Without Source A Prospective Multicenter Study
URL:	www.pec-online.com
Reference: (year, vol, page)	<i>Pediatr Emer Care 2010;26: 470-474</i>
Article summary:	<p>This articles evaluates the incidence and diagnosis of occult pneumonia in children under 3 years of age who present to the ED with fever ($\geq 39^{\circ}\text{C}$) and high WCC (≥ 20) but no focal signs of infection. A prospective study of 4 paediatric ED's in Spain evaluated 188 well appearing children who met criteria. CXR showed consolidation in 25 (13%) of cases. In the group <12 months of age 9 of 115 (7.8%) had radiologically confirmed pneumonia compared to 16 of 73 (21.9%) in the >12months group. WCC > 20, 000/mm³ and CRP>100mg/L appeared to be more suggestive of serious bacterial infection but no statistical correlation was found.</p> <p>Comment: The authors suggest that routine CXR may be indicated in this population – children <3yrs with fever $\geq 39^{\circ}\text{C}$ and WCC ≥ 20.</p>

Journal watch submission form

3. Journal name:	Hong Kong Journal of Emergency Medicine
Month:	July
1. Article title: (actual or revised)	A simplified appendicitis score in the diagnosis of acute appendicitis
URL:	
Reference: (year, vol, page)	<i>Hong Kong j.emerg.med. 2010;17:230-235</i>
Article summary:	<p>Diagnosing Acute appendicitis is often difficult. Use of scoring systems such as the Modified Alvarado score (MAS) may be useful but are often cumbersome. In this study, a more user-friendly Simplified Appendicitis Score (SAS) was evaluated in 238 patients admitted with suspected appendicitis. 5 variables were included: migratory pain, right lower quadrant [RLQ] tenderness, rebound pain, fever >37.3°C and WBC >12,000/uL with RLQ pain and WBC scoring double. In this study the SAS performed as well as the MAS with sensitivities around 91% for scores ≥6 and specificities of 90%.</p> <p>Comment: While these scoring systems may be useful they are not able to replace good clinical judgement.</p>

4. Journal name:	European Journal of Emergency Medicine
Month:	July
1. Article title: (actual or revised)	Patients' and relatives' view on witnessed resuscitation in the emergency department: a prospective study
URL:	
Reference: (year, vol, page)	<i>European Journal of Emergency Medicine 17:203-207</i>
Article summary:	<p>This study was a survey of the families of a 150 patients with life-threatening conditions in an ED in Belgium. Families were questioned as to their beliefs regarding resuscitation and whether they would want to be present. They found that 75% of family members wished to be present but only 49% did not fear that it would be too traumatic. One of the limitations was that this survey was done once patients had reached ICU and so did not include families whose loved ones had died in the ED.</p> <p>Comment: This study adds to the growing body of evidence that families wish to be present during resuscitation. However the authors note that institution of this policy does involve education of staff and families to allay their fears.</p>

Journal watch submission form

5. Journal name:	New England Journal of Medicine
Month:	July
1. Article title: (actual or revised)	CPR with Chest Compression Alone or with Rescue Breathing
URL:	
Reference: (year, vol, page)	<i>N Engl J Med 2010;363:423-33</i>
Article summary:	<p>This is a multicentre randomised control trial comparing prehospital bystander CPR with and without rescue breathing. The primary outcome evaluated was survival to hospital discharge and favourable neurologic outcome. Dispatcher assisted CPR instruction to 911 calls was randomised to chest compressions alone or 15 compressions to 2 breaths. 1941 patients were included in the trial: 981 in the compression only group and 960 in the rescue breathing group. There was no significant difference in the survival to hospital discharge group (12.5% vs 11%) and favourable neurologic output (14.4% vs 11.5%).</p> <p>Comment: This is one of 2 studies on prehospital chest compression only CPR published in this journal. These add to the growing body of evidence supporting compression only bystander CPR.</p>

6. Journal name:	Resuscitation
Month:	July
1. Article title: (actual or revised)	A randomised, simulated study assessing auscultation of heart rate at birth
URL:	www.elsevier.com/locate/resuscitation
Reference: (year, vol, page)	<i>Resuscitation 2010,81: 1000-1003</i>
Article summary:	<p>Heart rate (HR) assessment is an important part of the initial evaluation of the newborn. It may prompt intervention for resuscitation or stabilisation. The aim of this study was to evaluate whether birth attendants (doctors, midwives and nurses) were able to rapidly and accurately assess neonatal heart rate using a stethoscope in 3 different scenarios on a vital sim neonatal mannequin. The mean time to estimate HR varied between 7.8s in scenario 3 and 17s in scenario 1. Inaccurate assessments were made in 31% (1), 28%(2) and 26%(3). 73% of these were overestimates. 28% of all incorrect assessments would have prompted incorrect management.</p> <p>Comment: The authors note that more training is required and more research into more accurate assessments in neonates.</p>

Journal watch submission form

7. Journal name:	Academic Emergency Medicine
Month:	July
1. Article title: (actual or revised)	Emergency Medicine in the Developing World: A Delphi Study
URL:	www.aemj.org
Reference: (year, vol, page)	ACAD EMERG MED 2010; 17:765-774
Article summary:	<p>This paper reports the results of a Delphi study which aimed to establish the key areas of Emergency Medicine (EM) development in developing world settings. The 3 rounds of the Delphi produced consensus on 168 of 208 (81%) statements. These statements included broad areas such as: the scope of Emergency Medicine, staffing of ED's in developing countries, training in EM and research in EM.</p> <p>Comment: This is an important resource for developing countries aiming to establish EM systems and policies. It may guide future EM research and training.</p>

Journal watch submission form