
Palliative care (PC) in the ED is commenced for numerous and varied scenarios. It is imperative that as clinicians we have a practical understanding that allows the provision of a peaceful death no matter the preceding indication. The ED PC patient population includes: patients with terminal cancer suffering an acute deterioration or experiencing unresolved symptoms; patients with chronic medical conditions who are entering the terminal stage or have had an acute deterioration; and elderly or frail patients who will not survive the illness that has brought them to hospital. The area of PC that is specific to the ED and pre-hospital realms are unexpected acute unsurvivable traumatic and surgical conditions, including massive trauma, ruptured abdominal aortic aneurysm and intracerebral haemorrhage. The precipitous deterioration in acute or traumatic situations is confronting for staff and families, and requires special skills to manage. Clinicians need to address their personal areas of uncertainty and become comfortable with implementing PC in the ED; a departmental guideline is a very useful tool to aid clinical decision making.

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Background: Klebsiella species are problematic pathogens in neonatal units and may cause outbreaks, for which sources of transmission can be challenging to elucidate. We describe the use of whole genome sequencing (WGS) to investigate environmental sources of transmission during an outbreak of extended-spectrum-beta-lactamase (ESBL)-producing Klebsiella michiganensis colonizing neonates.Methods: Ceftriaxone-resistant Klebsiella spp. isolated from neonates (or their mothers) and the hospital environment were included. Short-read (Illumina) and long-read (MinION, Oxford Nanopore Technologies) sequencing was used to confirm species taxonomy, define antimicrobial resistance genes and determine phylogenetic relationships using single nucleotide polymorphism (SNP) profiling.Results: A total of 21 organisms (10 patient-derived and 11 environmental isolates) were sequenced. Standard laboratory methods identified the outbreak strain as an ESBL-producing Klebsiella oxytoca, but taxonomic assignment from WGS data suggested closer identity to Klebsiella michiganensis. Strains isolated from multiple detergent dispensing bottles were either identical or closely related by SNP comparison. Detergent bottles contaminated by K. michiganensis had been used for washing milk-expressing equipment. No new cases were identified once the detergent bottles were
removed. Conclusions: Environmental reservoirs may be an important source in outbreaks of multi-drug resistant organisms. WGS, in conjunction with traditional epidemiological investigation, can be instrumental in revealing routes of transmission and guiding infection control responses.

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BACKGROUND Intensive care follow-up clinics (ICFCs) have been implemented internationally with the aim to address the growing number of patients living with sequelae of critical illness and intensive care. However, data on Australian intensive care follow-up practice are rare.

OBJECTIVES The primary objective was to determine the proportion of Australian intensive care units (ICUs) that offer a dedicated ICFC to ICU survivors, with the intention of improving long-term outcomes of critical illness. Secondary objectives were to identify models of ICU follow-up and barriers to the implementation of ICFCs.

METHODS A custom-designed, pilot-tested 12-question online survey was sent to the nurse unit managers and medical directors of all 167 Australian ICUs listed in the database of the Australian and New Zealand Intensive Care Society. Outcome measures included proportion of ICUs offering ICFCs, details on types of follow-up services with staffing, funding source, and reasons for not providing ICU...

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Objective To describe the development of a patient and family-centred care (PFCC) conceptual framework within a small community Australian Hospital.

Methods A scoping review of scientific and grey literature and community hospital stakeholder discussions were used to identify and design a conceptual framework for PFCC across five core pillars of leadership, engagement, service delivery, learning and environment.

Results 107 publications were identified and 76 were included for data extraction. A draft framework was constructed and modified following consultation with hospital stakeholders across a small Australian Community Hospital. The ‘Caring Together’ framework outlines three core layers: (1) the focus of our care is the experiences of our consumers and staff; (2) concepts of leadership, environment, service delivery, engagement and learning; and (3) the overarching fundamental values of being heard, respected, valued and supported by staff and consumers at all levels in an organisation.

Conclusions The conceptual Caring Together framework structures key PFCC concepts across organisational priority areas within an Australian healthcare setting and can be used to guide implementation of PFCC at other small hospital facilities. Changes to national and state healthcare funding may help facilitate improved hospital facility implementation of PFCC, and ultimately improve consumer healthcare satisfaction and clinical outcomes.

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A new ED build creates a unique opportunity to improve the way we provide clinical care. Often, the focus is primarily on increasing clinical cubicle numbers but this may have a negligible, or even negative impact on care delivery. Instead, Australian EDs should examine the entire patient journey to inform design, reviewing outdated triage and registration models and maximising physical capacity by introducing advanced split-flow models that optimise clinical space and provide high-risk patients faster access to clinical care. Efficient ED patient flow is critical for success and is closely linked with departmental design, but too often this design process is delegated to architects with limited knowledge of ED function and with limited input from emergency clinicians. This relationship between clinicians and architects should remain collaborative but requires re-alignment. Independent, expert ED-specific designers can empower and provide valuable support for clinician-led design teams in their interactions with architects.


Antimicrobial de-escalation (ADE) is a component of antimicrobial stewardship (AMS) aimed to reduce exposure to broad-spectrum antimicrobials. In the intensive care unit, ADE is a strong recommendation that is moderately applied in clinical practice. Following a systematic review of the literature, we assessed the studies identified on the topic which included one randomized controlled trial and 20 observational studies. The literature shows a low level of evidence, although observational studies suggested that this procedure is safe. The effects of ADE on the level of resistance of ecological systems and especially on the microbiota are unclear. The reviewers recommend de-escalating antimicrobial treatment in patients requiring long-term antibiotic therapy and considering de-escalation in short-term treatments.


Methods: We used recruitment and screening logs from the SAFE, NICE-SUGAR, RENAL, CHEST and ADRENAL trials, five of the largest critical care RCTs. We quantified the extent of recruitment asymmetry between sites using Lorenz curves and Gini coefficients and assessed whether the recruitment distribution across sites follow the Pareto principle, which states that 80% of effects come from 20% of causes. Peak recruitment rates and growth in participating sites were calculated.

AB- Results: In total, 25,412 patients were randomised in 99 intensive care units (ICUs) for the five trials. Distribution of recruitment was asymmetric, with a small number of ICUs recruiting a large proportion of the patients. The Gini coefficients ranged from 0.14 to 0.52. The time to peak recruitment rate ranged from 7 to 41 months and was variable (7, 31, 41, 10 and 40 months). Over time, the proportion of recruitment at non-tertiary ICUs increased from 15% to 34%.

AB- Conclusions: There is asymmetry of recruitment with a small proportion of ICUs recruiting a large proportion of patients. The distributions of recruitment were not consistent with the Pareto principle. There has been increasing participation of non-tertiary ICUs in clinical trials.

Abstract
Leiomyosarcomas are rare, primary malignancies that can be found in the small bowel in a minority of cases. The management of these visceral sarcomas remains controversial, with surgical resection forming the mainstay, being optimally achieved in a unit familiar with the management of sarcomas. These tumours are difficult to diagnose based on history and are challenging to localize on conventional imaging modalities. We report a case of a 61-year-old female who proceeded to emergent laparotomy with imaging suggestive of small bowel ischaemia secondary to portal venous thrombosis. Incidental leiomyosarcoma was noted on histology and was discussed at local multidisciplinary meeting regarding further management.


OBJECTIVES: Expiratory radiographs are sometimes performed in addition to inspiratory radiographs when a diagnosis of pneumothorax is suspected. There is little published evidence to support this practice and most studies suggest the additional radiograph does not confer any benefit in terms of increased sensitivity. The present study is the first to assess if specialist emergency physicians are more likely to detect a pneumothorax on an inspiratory radiograph compared to an expiratory radiograph.

METHODS:
Across two urban district EDs 103 paired radiographs positive for pneumothorax and 112 negative controls were identified for inclusion in the study. These were reviewed by three specialist emergency physicians who rated them as either positive or negative for pneumothorax.

RESULTS: The mean sensitivity for the three reviewers was 84.8% (95% CI 82.0-87.5) for the inspiratory radiographs and 91.9% (95% CI 88.2-95.6) for the expiratory radiographs, a mean absolute difference of 7.1% (95% CI 2.2-12.1, P = 0.025) in favour of expiratory radiographs.

CONCLUSIONS: When reviewed by emergency physicians the present study found expiratory radiographs confer an increase in sensitivity for the diagnosis of pneumothorax compared with inspiratory radiographs. In certain patients where the clinical suspicion for pneumothorax is high performing an expiratory radiograph may increase the likelihood of the diagnosis being made in the ED. 

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