

lists in both THs (91%) and DGHs (84%).

On questioning, lead clinicians were in favour of nurse endoscopists performing diagnostic OGD (TH=68%, DGH=80%) and flexible sigmoidoscopy (TH=79%, DGH=91%). However, they were not in favour for therapeutic OGD (TH=74%, DGH=61%), diagnostic full colonoscopy (TH=74%, DGH=52%) and therapeutic full colonoscopy (TH=84%, DGH=71%). Concerns expressed included the need for consultant cover and a lack of knowledge of possible medical complications. We were surprised by the range of diagnostic and therapeutic endoscopic procedures currently practised by nurse endoscopists in the UK.

The lack of standardisation and regulation for training nurse endoscopists for procedures other than flexible sigmoidoscopy gives cause for concern⁴. The implementation of current Joint Advisory Committee regulations in endoscopic training would involve lengthy apprenticeships, especially if therapeutic skills were to be developed. Nevertheless, we envisage a role for nurse endoscopy in the future provision of endoscopic services in the NHS, be it in a restrained capacity.

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Respiratory rate – an under-documented clinical assessment

The physiological measurements of pulse, systolic blood pressure, respiratory rate, temperature and consciousness are increasingly used both as clinical markers of the severity of condition and to highlight patients at risk of deterioration^{1,2}.

We undertook a retrospective case note analysis of all medical patients admitted through a general medical admissions unit over a two-week period. Although most medical documentation was satisfactory, the respiratory rate was recorded in only 58% of clerkings (n=159). Even when the working diagnosis was of asthma, exacerbation of chronic obstructive pulmonary disease, pulmonary embolus, pneumonia or pulmonary oedema, the respiratory rate was not recorded in 27% of admissions. In our series, the respiratory rate was documented in only 65% of emergency medical patients with chest signs.

Tachypnoea is a sensitive but non-specific sign. It is a crucial element in the initial severity assessment of acute asthma³. A normal respiratory rate is a negative predictor for the diagnosis of pulmonary embolus⁴. Metabolic acidosis, the reflection of inadequate organ perfusion, renal failure or indeed poisoning, is an important cause of compensatory tachypnoea.

This study emphasises the need for detailed clinical examination and adequate written documentation of physiological measurements in all acutely ill patients for both clinical and medico-legal reasons. Some centres have found a severity marker stamp improves recording of these data⁵. Our unit is now evaluating the adoption of physiological screening tools to detect sick patients.

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