patients. With the current time pressures and the high turnover of patients, this was not easy for clinicians. Also, at a more basic level, busy clinical and nursing staff would often simply forget to apply the specifics of the pathway to their patients.

We noted that the feeling among some accident and emergency department staff was that there is no need for a new protocol in the management of patients with sepsis. Many staff thought that most of the interventions described in the protocol, such as blood tests, blood cultures, fluid boluses and antibiotics, were already being implemented in an appropriate and timely manner, often well within the recommended 6 h stated in the sepsis bundle. In particular, we noted a reluctance to measure concentrations of serum lactate. This suggests a lack of understanding of the importance of this biochemical marker. Indeed, hyperlactataemia is most important in assessing any patient with sepsis, and ignoring it could easily lead to underestimation of the severity of illness in a patient with sepsis.²

It may therefore prove to be far harder to implement these guidelines than was originally envisaged, especially with accident and emergency departments under increasing pressure to meet targets. Education will obviously play a key part; it is evident that there is a disparity between the evidence-based practice we strive for and the daily clinical practice we undertake. The sepsis bundle can save lives only if it is implemented correctly and appropriately by those making initial assessment and management decisions in patients with sepsis.

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Preventing glass injuries in the emergency department

Glass vials are widely used in emergency departments. Opening a glass vial can be a complicated task as the vial may shatter, resulting in injury which may require treatment. The authors used a novel and safe technique for opening glass vials. Using a 2 ml syringe, after removing the plunger, the larger open end is placed on top of the vial and the top of the vial is broken off. The glass end is contained in the syringe and may then be safely disposed of (fig 1). The 2 ml syringe effectively opens 1 ml vials, and a 5 ml syringe is used for opening 10 ml vials. Of importance is that on some vials, there is a blue dot that indicates a weak spot. Ensure that the blue dot is facing away from you and break away from the blue dot towards you.

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Figure 1 The top of the vial contained in the syringe.

Sedate with caution

We would like to comment on the sedation practice in the emergency department as described by Duncan *et al.*¹

We feel that there is too much reliance on oxygen saturation in patients undergoing sedation while they are receiving supplementary oxygen. This creates a false sense of security. The end-tidal carbon dioxide level is a better indicator of adequacy of ventilation, although it is seldom used during sedation. Monitoring of respiratory rate, respiratory effort and end-tidal CO₂ may identify patients at risk of hypoventilation from oversedation.

Another concern is the use of different opioids in a single patient journey, as there are potential interactions in terms of analgesic efficacy and side effects.²

The dose of midazolam should be reduced in elderly patients and in those with considerable comorbidity. Although reversal of midazolam is possible with flumazenil (Anexate-R), this may be associated with patients experiencing arrhythmias, hypertension and even convulsions. For sedation in elderly patients, we use 0.5-1 mg midazolam intravenously and fentanyl by titration, and wait for a couple of minutes. We then use small boluses of intravenous propofol or inhalation of a low concentration of sevoflurane in an air/oxygen mixture to maintain sedation. We monitor the electrocardiogram, blood pressure, oxygen saturation and the end tidal CO₂. We occasionally add nitrous oxide both as an analgesic and as a hypnotic agent.

We understand the service need for sedation to be provided by non-anaesthetists. However, a multimodal, tailor-made approach to sedation of a patient will provide the best outcome, especially in frail and elderly patients. These patients would be better-off under monitored anaesthetic care.

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