AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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28 September 2020

On the Radar is a summary of some of the recent publications in the areas of safety and quality in health care. Inclusion in this document is not an endorsement or recommendation of any publication or provider. Access to particular documents may depend on whether they are Open Access or not, and/or your individual or institutional access to subscription sites/services. Material that may require subscription is included as it is considered relevant.

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On the Radar
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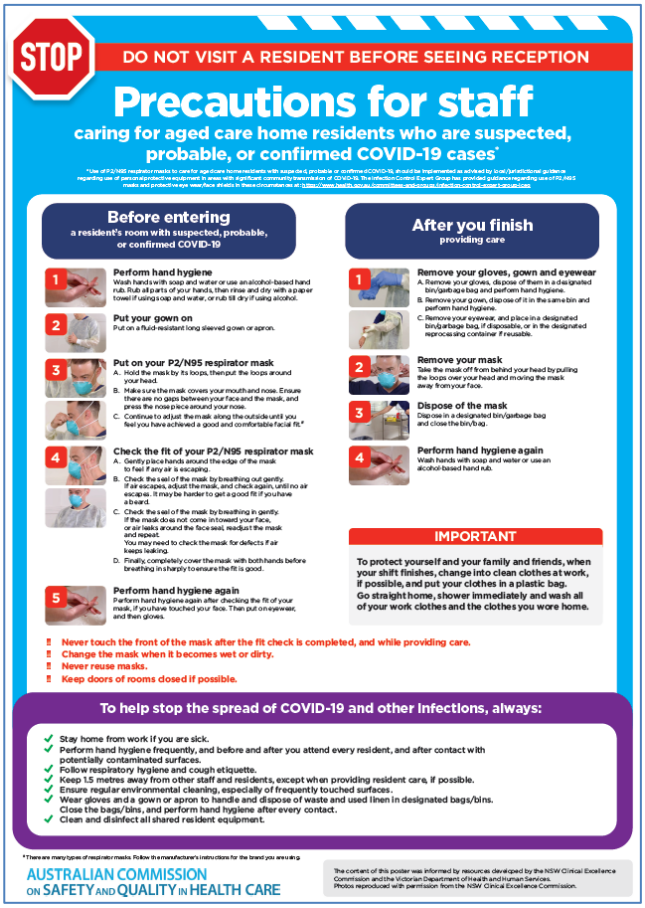
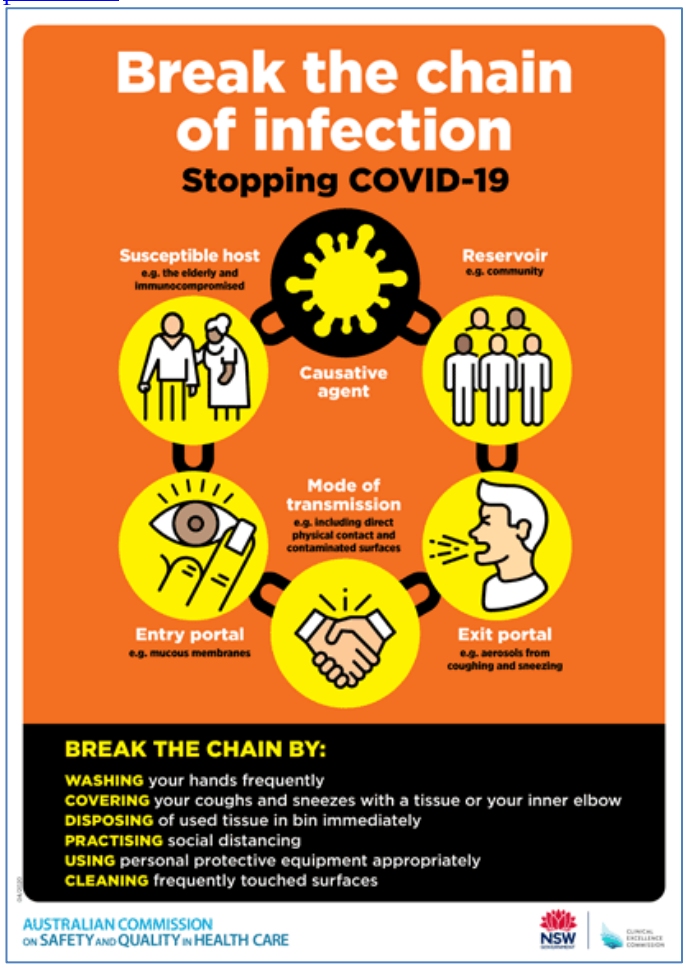
COVID-19 resources
https://www.safetyandquality.gov.au/covid-19
The Australian Commission on Safety and Quality in Health Care has developed a number of resources to assist healthcare organisations, facilities and clinicians. These and other material on COVID-19 are available at https://www.safetyandquality.gov.au/covid-19
The latest additions include:

- *COVID-19: Aged care staff infection prevention and control precautions* *poster*
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-aged-care-staff-infection-prevention-and-control-precautions-poster

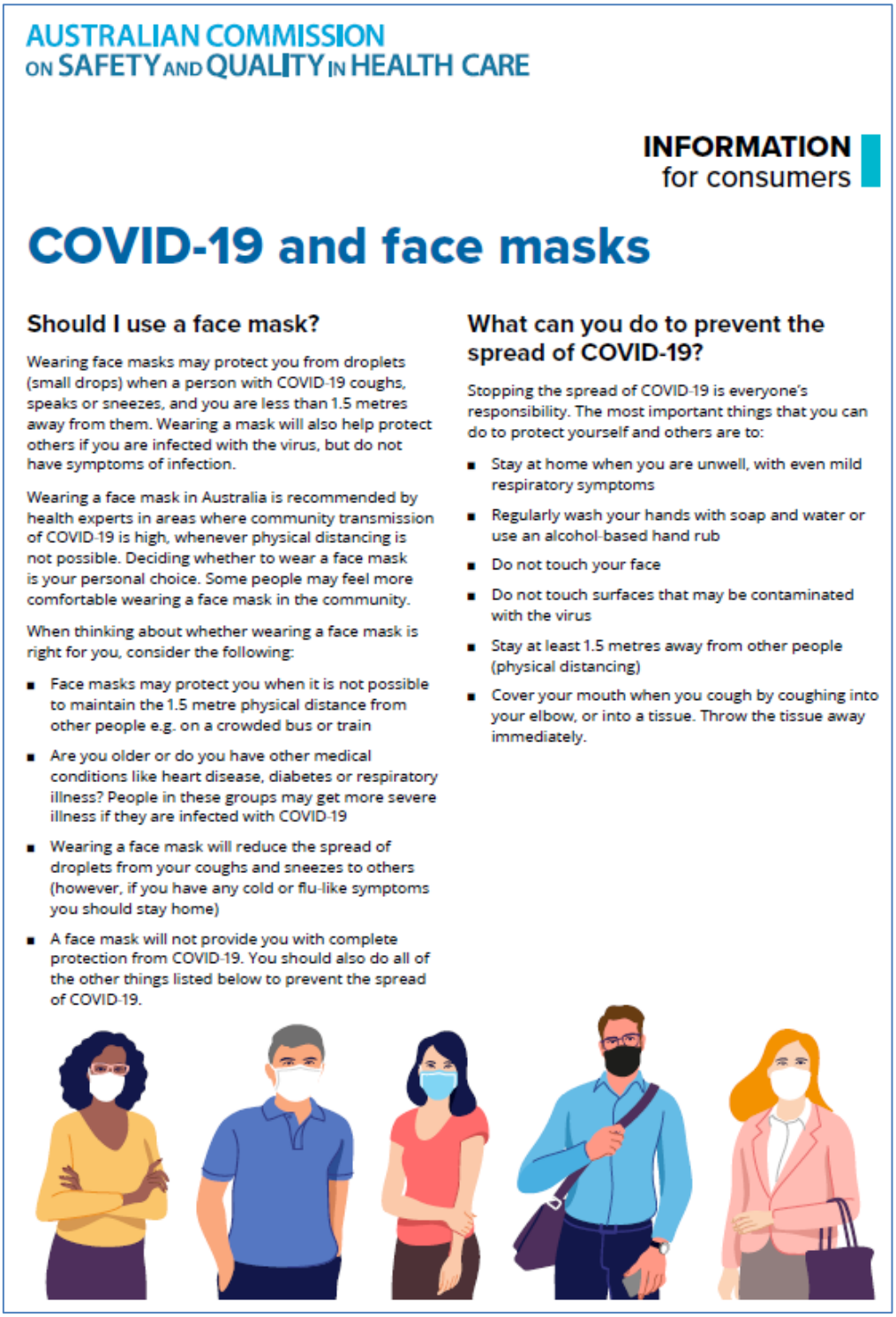


- *Environmental Cleaning and Infection Prevention and Control*
  www.safetyandquality.gov.au/environmental-cleaning
- *Infection prevention and control Covid-19 PPE* poster
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/infection-prevention-and-control-covid-19-personal-protective-equipment
- *Special precautions for Covid-19 designated zones* poster
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/special-precautions-covid-19-designated-zones
- *COVID-19 infection prevention and control risk management – Guidance*
  https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-infection-prevention-and-control-risk-management-guidance
- *Safe care for people with cognitive impairment during COVID-19*
  https://www.safetyandquality.gov.au/our-work/cognitive-impairment/cognitive-impairment-and-covid-19

- **Medicines Management COVID-19** https://www.safetyandquality.gov.au/our-work/medication-safety/medicines-management-covid-19, including position statements on medicine-related issues
    - *Managing fever associated with COVID-19*
    - *Managing a sore throat associated with COVID-19*
    - *ACE inhibitors and ARBs in COVID-19*
    - *Clozapine in COVID-19*
    - *Management of patients on oral anticoagulants during COVID-19*
    - *Ascorbic Acid: Intravenous high dose in COVID-19*
    - *Treatment in acute care, including oxygen therapy and medicines to support intubation*
    - *Nebulisation and COVID-19*
    - *Managing intranasal administration of medicines during COVID-19*
    - *Ongoing medicines management in high-risk patients*
    - *Medicines shortages*
    - *Conserving medicines*
    - *Intravenous medicines administration in the event of an infusion pump shortage*
- *Potential medicines to treat COVID-19* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/potential-medicines-treat-covid-19
- *Break the chain of infection: Stopping COVID-19* poster https://www.safetyandquality.gov.au/publications-and-resources/resource-library/break-chain-poster-a3



- *COVID-19: Elective surgery and infection prevention and control precautions* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-elective-surgery-and-infection-prevention-and-control-precautions
- *FAQs for clinicians on elective surgery* https://www.safetyandquality.gov.au/node/5724
- *FAQs for consumers on elective surgery* https://www.safetyandquality.gov.au/node/5725
- *FAQs on community use of face masks* https://www.safetyandquality.gov.au/faqs-community-use-face-masks
- *COVID-19 and face masks – Information for consumers* https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-and-face-masks-information-consumers



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

INFORMATION for consumers

COVID-19 and face masks

Should I use a face mask?

Wearing face masks may protect you from droplets (small drops) when a person with COVID-19 coughs, speaks or sneezes, and you are less than 1.5 metres away from them. Wearing a mask will also help protect others if you are infected with the virus, but do not have symptoms of infection.

Wearing a face mask in Australia is recommended by health experts in areas where community transmission of COVID-19 is high, whenever physical distancing is not possible. Deciding whether to wear a face mask is your personal choice. Some people may feel more comfortable wearing a face mask in the community.

When thinking about whether wearing a face mask is right for you, consider the following:

- Face masks may protect you when it is not possible to maintain the 1.5 metre physical distance from other people e.g. on a crowded bus or train
- Are you older or do you have other medical conditions like heart disease, diabetes or respiratory illness? People in these groups may get more severe illness if they are infected with COVID-19
- Wearing a face mask will reduce the spread of droplets from your coughs and sneezes to others (however, if you have any cold or flu-like symptoms you should stay home)
- A face mask will not provide you with complete protection from COVID-19. You should also do all of the other things listed below to prevent the spread of COVID-19.

What can you do to prevent the spread of COVID-19?

Stopping the spread of COVID-19 is everyone's responsibility. The most important things that you can do to protect yourself and others are to:

- Stay at home when you are unwell, with even mild respiratory symptoms
- Regularly wash your hands with soap and water or use an alcohol-based hand rub
- Do not touch your face
- Do not touch surfaces that may be contaminated with the virus
- Stay at least 1.5 metres away from other people (physical distancing)
- Cover your mouth when you cough by coughing into your elbow, or into a tissue. Throw the tissue away immediately.

Antimicrobial medicines dispensing from 2013–14 to 2017–18
https://www.safetyandquality.gov.au/our-work/healthcare-variation/antimicrobial-medicines-dispensing-2013-14-2017-18

The Australian Commission on Safety and Quality in Health Care has released a new report on antimicrobial medicines use in Australia that has revealed a sustained pattern of high use in some of the most disadvantaged areas of major cities.

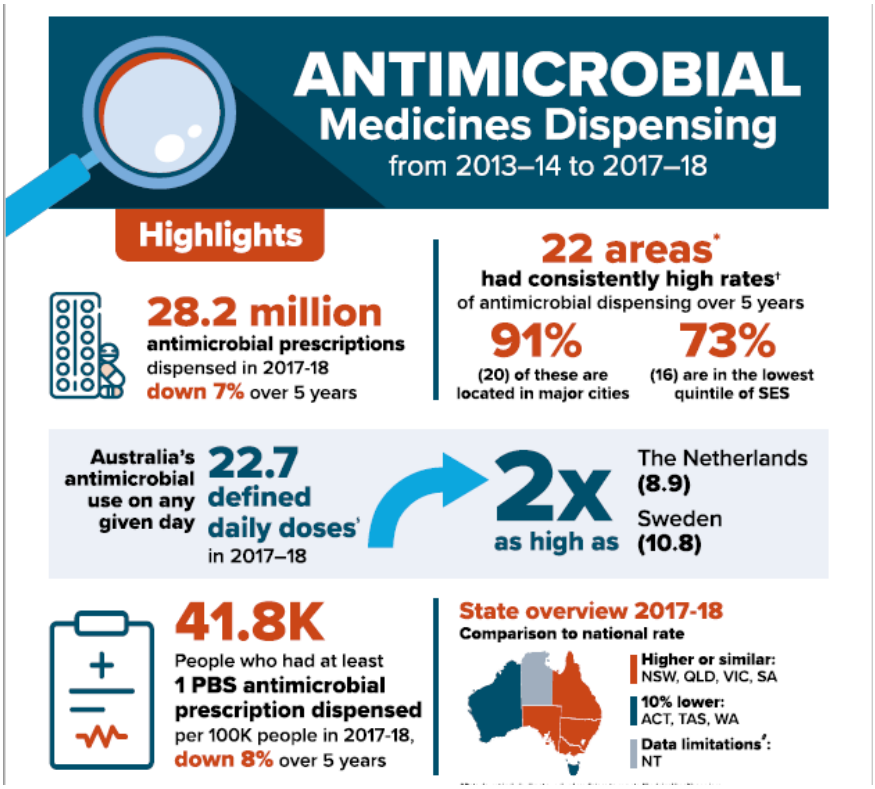
The *Antimicrobial Medicines Dispensing from 2013–14 to 2017–18* report also has some encouraging findings, with a downward trend in national antimicrobial dispensing rates, which fell 13.3% over five years.

For the first time, the new-format interactive report analyses antimicrobial dispensing over five years at a range of levels – national, state and territory, Primary Health Network (PHN) and local area. The report builds on the findings of the *Third Australian Atlas of Healthcare Variation*, which examined antimicrobial medicines dispensing from 2013–14 to 2016–17.

Data from the interactive report can be used by health service organisations, PHNs, general practitioners and other clinicians to review rates of antimicrobial dispensing in their local area and compare them with the rates for similar areas.

The report helps identify areas that may benefit from further investigation and targeted strategies to improve appropriate prescribing of antimicrobial medicines.

Australia's antimicrobial prescription rate remains high by international standards, and is double that of comparable OECD countries such as The Netherlands and Sweden. While there has been a modest decline in antimicrobial use over the past five years, the report indicates potential overuse in some geographical areas. Outer areas of Sydney, Brisbane and Melbourne were found to have the highest rates of antimicrobial dispensing year after year.



Reports

What influences improvement processes in healthcare? A rapid evidence review
Ali G-C, Altenhofer M, Gloinson ER, Marjanovic S
Santa Monica and Cambridge: RAND Corporation; 2020. p. 106.

URL	https://www.rand.org/pubs/research_reports/RRA440-1.html
Notes	The Healthcare Improvement Studies (THIS) Institute at the University of Cambridge commissioned RAND Europe to conduct a rapid review of academic reviews and grey literature covering the influences on improvement processes in healthcare. Based on 38 academic and 16 grey literature publications, the review found six key factors influence the implementation of improvement efforts: • Leadership • Relationships and interactions that support an improvement culture • Skills and competencies • Use of data • Patient and public involvement, engagement and participation • Working as an interconnected system of individuals and organisations, influenced by internal and external contexts.

Patient and Family Advisory Council Leaders' Guide for Diagnostic Quality and Safety
Society to Improve Diagnosis in Medicine
Evanston: Society to Improve Diagnosis in Medicine; 2020. p. 17.

Patient and Family Advisory Council Guide for Hospital and Health System Leaders for Diagnostic Quality and Safety
Society to Improve Diagnosis in Medicine
Evanston: Society to Improve Diagnosis in Medicine; 2020. p. 16.

URL	https://www.improvediagnosis.org/pfac-guides/
Notes	With the continuing interest in issues around diagnosis (see below for some of the most recent literature), these two guides have been produced by the (US) Society to Improve Diagnosis in Medicine. According to the Society's webpage, these guides are intended to serve as compendia of best and promising practices for use by Patient and Family Advisory Councils (PFACs) and for leadership in the hospitals and health systems that have PFACs. Each guide provides foundational education about diagnostic errors and tangible ideas and suggestions for PFACs and their hospital or health system leadership to employ as they work to tackle diagnostic quality and safety.

Journal articles

Prevalence and characterisation of diagnostic error among 7-day all-cause hospital medicine readmissions: a retrospective cohort study
Raffel KE, Kantor MA, Barish P, Esmaili A, Lim H, Xue F, et al
BMJ Quality & Safety. 2020 [epub].

DOI	http://doi.org/10.1136/bmjqs-2020-010896
Notes	This addition to diagnostic error literature used a retrospective cohort study to examine 376 adult patients readmitted to a US teaching hospital within 7 days of hospital discharge. The study found that over a year (2018), 5.6% of readmissions had at least one diagnostic error during the index admissions. The diagnostic errors were largely to diagnostic reasoning, including failure to order needed tests, erroneous interpretation of tests, and failure to consider the correct diagnosis. The majority of the diagnostic errors resulted in some form of clinical impact, including short-term morbidity and readmissions.

Diagnostic error: incidence, impacts, causes and preventive strategies
Scott IA, Crock C
Medical Journal of Australia. 2020 [epub].

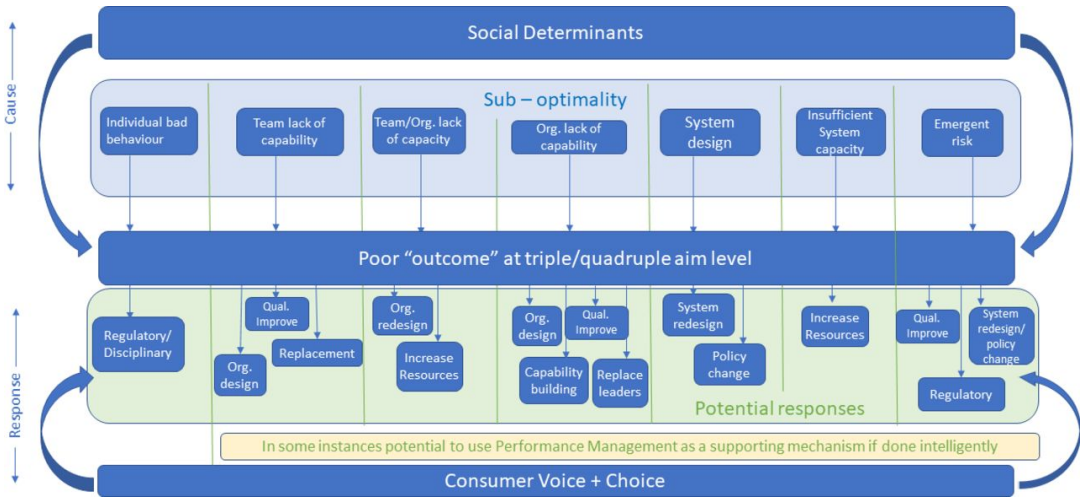
DOI	https://doi.org/10.5694/mja2.50771
Notes	This Perspectives piece summarises the current thinking around diagnostic error, and starts by citing some of the more eye-catching figures from the literature. For example: • Some form of diagnostic error occurs in up to one in seven clinical encounters, and most are preventable. • Diagnostic error comprising missed, wrong or delayed diagnoses affects between 8% and 15% of all hospital admissions in the United States, with similar rates among patients with common diseases attending outpatient clinics. • As many as 1.1% of adult hospital admissions will involve diagnostic error that causes harm to patients. • Nearly a third of all preventable deaths in acute hospitals in the United Kingdom are attributed to diagnostic error. • In Australia, an estimated 140 000 cases of diagnostic error occur each year, with 21 000 cases of serious harm and 2000–4000 deaths. • Almost one in two malpractice claims against general practitioners involves diagnostic error. • More than 80% of diagnostic errors are deemed preventable. The piece proceeds to provide brief statements on types of diagnostic error, theories of diagnostic reasoning, and strategies for preventing diagnostic error. The piece also notes the establishment of an Australian and New Zealand Affiliate of the US Society to Improve Diagnosis in Medicine (ANZA-SIDM).

Communication tools in the COVID-19 era and beyond which can optimise professional practice and patient care
Clement KD, Zimmermann EF, Bhatt NR, Light A, Gao C, Kulkarni M, et al
BMJ Innovations. 2020 [epub].

DOI	https://doi.org/10.1136/bmjinnov-2020-000465
Notes	The COVID-19 pandemic has seen many changes brought in rapidly. This piece looks at how communications has changed and may continue to be changed. The authors aim to 'summarise the variety of electronic communication platforms and tools available for clinicians and patients, detailing their utility, pros and cons, and some 'tips and tricks' from our experience'. Among the observations and advice, the authors offer their 'Seven Ps for a successful virtual clinic': Practice, Patient-centred, Professional, Plan and prepare, Perform the consultation, Perfect and Precision'.

Practice	Ensure familiarity with the system, both the clinical applications and communication tools, especially if working off-site in advance of your first clinic. Check audiovisual equipment is working before initiating any consultations.
Patient- centred	Decide whether the consultation will be audio only or with video conferencing, and send information/instructions in advance about what to expect from the consultation (including the time, date and duration). Confirm that the patent is able to speak confidentially and that they are comfortable using the technology/device chosen for their consultation.
Professional	Find a suitable quiet space (particularly if consulting from home) to avoid disturbances and maintain patient confidentiality. If examination is absolutely necessary (either live video or via picture messaging) explain the need clearly, recheck consent and preserve dignity. Be aware that some applications (including the patient's) may allow the recording of consultations.
Plan and prepare	Review the patient's file in detail before the consultation to anticipate issues including any difficult discussions or language barriers (although it may be possible to include an interpreter in a three-way call). It may be necessary to make alternative arrangements, including changing to an 'in-person' consultation depending on circumstance.
Perform the consultation	Devise methods of denoting that a patient is about to be contacted by you to avoid two clinicians in the same virtual clinic ringing the same patient. Set expectations with the patient at the start of the consultation. Headphones are helpful to avoid feedback. A screen-sharing option is useful to show scans. Decide how many times to call the patient if unable to connect first time and consider options for leaving a message on an answerphone. In particular, avoid identifiable or sensitive information if the answerphone is not personalised (and therefore the possibility of a wrong number).
Perfect	It takes time to learn how to set up a virtual clinic and do it well; consultations early in the learning curve are likely to take longer than with experience. Perfect methods of eliciting patients' ideas, concerns and expectations and methods to summarise the plan and draw the consultation to a close. Reflect on the process and get feedback from colleagues and patients to improve the process in the future.
Precision	Document the consultation in equivalent fashion to an 'in-person' consultation including letter dictation and arranging follow-up tests/appointments. State that the consultation occurred remotely and explain why.

Well spotted: but now you need to do something
Hamblin R, Shuker C
BMJ Quality & Safety. 2020 [epub].

DOI	https://doi.org/10.1136/bmjqs-2019-010659
Notes	Editorial that in reflecting on an article on using routinely available data for early warning of service failure then proceeds to consider not only the causes of safety and quality lapses, how to detect them but also the need to be able to adequately understand and respond to (or prevent) such failures. 

Hospital- and system-wide interventions for health care-associated infections: A systematic review
Maurer NR, Hogan TH, Walker DM
Medical Care Research and Review. 2020:1077558720952921.

DOI	http://doi.org/10.1177/1077558720952921
Notes	Paper reporting on a systematic review of interventions to address healthcare-associated infections (HAI). Based on 96 studies published between 2008 and 2019, the review found the 'literature's methodologic and reporting quality was generally poor'. However, the review did identify a number of strategies for reducing HAIs, including enhanced environmental cleaning; electronic health record implementation; infection control programs; hand hygiene promotion; and hospital-wide cultural transformations.

For information on the Commission's work on healthcare-associated infection, see https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection

Opioid Stewardship Program and Postoperative Adverse Events: A Difference-in-differences Cohort Study
Barreveld AM, McCarthy RJ, Elkassabany N, Mariano ER, Sites B, Ghosh R, et al
Anesthesiology. 2020;132(6):1558-1568.

DOI	http://doi.org/10.1097/aln.0000000000003238
Notes	Paper reporting on the implementation and impact of an opioid stewardship program. The 6-month opioid use educational program consisting of webinars on pain assessment, postoperative and multimodal pain opioid management, safer opioid use, and preventing addiction coupled with on-site coaching and monthly assessments reports was implemented in 31 hospitals with outcomes compared with 33 control hospitals for 12 months before and after the intervention. The study found the 'intervention did not reduce opioid adverse events or alter opioid use in hospitalized patients'.

For information on the Commission's work on medication safety, see
https://www.safetyandquality.gov.au/our-work/medication-safety

Emergency department monitor alarms rarely change clinical management: An observational study
Fleischman W, Ciliberto B, Rozanski N, Parwani V, Bernstein SL
The American Journal of Emergency Medicine. 2020;38(6):1072-1076.

DOI	http://doi.org/10.1016/j.ajem.2019.158370
Notes	Paper reporting on a prospective, observational study conducted in an urban, academic emergency department (ED) in which an ED physician completed 53 hours of observation, recording patient characteristics, alarm type, staff response, whether the alarm was likely real or false, and whether it changed clinical management. In the 53 hours, there were 1049 alarms associated with 146 patients and these alarms changed clinical management in just 8 out of 1049 observed alarms in 5 out of the 146 patients. Staff did not observably respond to most alarms (63%).

Association of Intra-arrest Transport vs Continued On-Scene Resuscitation With Survival to Hospital Discharge Among Patients With Out-of-Hospital Cardiac Arrest
Grunau B, Kime N, Leroux B, Rea T, Van Belle G, Menegazzi JJ, et al
JAMA. 2020;324(11):1058-1067.

DOI	https://doi.org/10.1001/jama.2020.14185
Notes	Apparently, different locations have differing approaches to handling cardiac arrests that happen in the community. In some locations emergency responders will take little action on the spot, opting for rapid transportation to hospital (the "scoop and run" approach) while in others the standard response is to treat the patient at the scene ("stay and play'). This article reports on a cohort study that examined 27,705 patients who suffered out-of-hospital cardiac arrests in the USA and Canada. The study found that 'intra-arrest transport compared with continued on-scene resuscitation had a probability of survival to hospital discharge of 4.0% vs 8.5%, a difference that was statistically significant.'

BMJ Quality & Safety
October 2020 - Volume 29 - 10

URL	https://qualitysafety.bmj.com/content/29/10
Notes	A new issue of *BMJ Quality & Safety* has been published. Many of the papers in this issue have been referred to in previous editions of *On the Radar* (when they were released online). Articles in this issue of *BMJ Quality & Safety* include: • Editorial: **Whiteboards**: important part of the toolbox for improving **patient understanding during hospitalisation** (Sara Dunbar, Kathlyn E Fletcher) • Editorial: **Social emotion and patient safety**: an important and understudied intersection (Jane Heyhoe, Rebecca Lawton) • Editorial: Choosing quality problems wisely: identifying **improvements worth developing and sustaining** (Christine Soong, Hyung J Cho, K G Shojania) • **Do bedside whiteboards enhance communication in hospitals?** An exploratory multimethod study of patient and nurse perspectives (Anupama Goyal, Hanna Glanzman, Martha Quinn, Komalpreet Tur, Sweta Singh, Suzanne Winter, Ashley Snyder, Vineet Chopra) • **Emotionally evocative patients in the emergency department**: a mixed methods investigation of providers' reported emotions and implications for patient safety (Linda M Isbell, Julia Tager, Kendall Beals, Guanyu Liu) • **What do emergency department physicians and nurses feel?** A qualitative study of emotions, triggers, regulation strategies, and effects on patient care

	(Linda M Isbell, Edwin D Boudreaux, Hannah Chimowitz, Guanyu Liu, Emma Cyr, Ezekiel Kimball) • Impact of an education and multilevel social comparison–based intervention bundle on **use of routine blood tests in hospitalised patients** at an academic tertiary care hospital: a controlled pre-intervention post-intervention study (Anshula Ambasta, Irene Wai Yan Ma, Stephen Woo, Kevin Lonergan, Elizabeth Mackay, Tyler Williamson) • The discontinuation of contact precautions for **methicillin-resistant *Staphylococcus aureus* and vancomycin-resistant Enterococcus**: Impact upon patient adverse events and hospital operations (Gregory M Schrank, Graham M Snyder, Roger B Davis, Westyn Branch-Elliman, Sharon B Wright) • Impact **of multidisciplinary team huddles on patient safety**: a systematic review and proposed taxonomy (Brian J Franklin, Tejal K Gandhi, David W Bates, Nadia Huancahuari, Charles A Morris, Madelyn Pearson, Michelle Beth Bass, Eric Goralnick) • **Effects of CPOE-based medication ordering on outcomes**: an overview of systematic reviews (Joanna Abraham, Spyros Kitsiou, Alicia Meng, Shirley Burton, Haleh Vatani, Thomas Kannampallil) • **Empowering patients** and reducing inequities: is there potential in **sharing clinical notes**? (Charlotte Blease, Leonor Fernandez, Sigall K Bell, Tom Delbanco, Catherine DesRoches) • **Resilience and regulation**, an odd couple? Consequences of Safety-II on governmental regulation of healthcare quality (Ian Leistikow, Roland A Bal)

Health Expectations
Vol. 23, No. 4, August 2020

URL	https://onlinelibrary.wiley.com/toc/13697625/2020/23/4
Notes	A new issue of *Health Expectations* has been published. Articles in this issue of *Health Expectations* include: • Utilizing **patient advocates in Parkinson's disease**: A proposed framework for patient engagement and the modern metrics that can determine its success (Megan Feeney, Christiana Evers, D Agpalo, L Cone, J Fleisher, K Schroeder) • A systematic review of factors associated with **side-effect expectations from medical interventions** (Louise E Smith, Rebecca K Webster, G James Rubin) • The reported impact of **public involvement in biobanks**: A scoping review (Lidia Luna Puerta, Will Kendall, Bethan Davies, Sophie Day, Helen Ward) • Patient and Public **Involvement of young people with a chronic condition in projects in health and social care**: A scoping review (Femke van Schelven, Hennie Boeije, Veerle Mariën, Jany Rademakers) • **Public acceptability of public health policy to improve population health**: A population-based survey (Catherine A Sharp, Mark A Bellis, Karen Hughes, Kat Ford, Lisa C G Di Lemma) • Appropriating and asserting **power on inflammatory arthritis teams**: A social network perspective (Wendy Hartford, Catherine Backman, Linda C Li, Annette McKinnon, Laura Nimmon) • A co-designed framework to support and sustain **patient and family engagement in health-care decision making** (Tamara L McCarron, Thomas Noseworthy, Karen Moffat, Gloria Wilkinson, Sandra Zelinsky, Deborah White, Derek Hassay, Diane L Lorenzetti, Nancy J Marlett)

	• Falling into a deep dark hole: **Tongan people's perceptions of being at risk of developing type 2 diabetes** (Julienne Faletau, Vili Nosa, Rosie Dobson, Maryann Heather, Judith McCool) • Patient and clinician perspectives on a **patient-facing dashboard that visualizes patient reported outcomes in rheumatoid arthritis** (Lucy H Liu, Sarah B Garrett, Jing Li, Dana Ragouzeos, Beth Berrean, Daniel Dohan, Patricia P Katz, Jennifer L Barton, Jinoos Yazdany, Gabriela Schmajuk) • **Children's rights** as law in Sweden–every health-care encounter needs to meet the child's needs (Sofia Sahlberg, Katarina Karlsson, Laura Darcy) • 'It just wasn't going to be heard': A mixed methods study to compare different ways of **involving people with diabetes and health-care professionals in health intervention research** (Emmy Racine, Fiona Riordan, Eunice Phillip, Grainne Flynn, Sheena McHugh, Patricia M Kearney) • **Genetic testing for hereditary cancer syndromes**: patient recommendations for improved risk communication (Samantha Pollard, Steve Kalloger, Deirdre Weymann, Sophie Sun, Jennifer Nuk, Kasmintan A Schrader, Dean A Regier) • **Patient participation in gastrointestinal endoscopy** — From patients' perspectives (Hanna Dubois, Johan Creutzfeldt, M Törnqvist, M Bergenmar) • The revised **Patient Perception of Patient-Centeredness Questionnaire**: Exploring the factor structure in French-speaking patients with multimorbidity (Tu Ngoc Nguyen, Patrice Alain Ngangue, Bridget L Ryan, Moira Stewart, Judith Belle Brown, Tarek Bouhali, Martin Fortin) • Mainstreaming **public involvement in a complex research collaboration**: A theory-informed evaluation (Fiona Ward, Jennie Popay, Ana Porroche-Escudero, Dorcas Akeju, Saiqa Ahmed, Jane Cloke, Koser Khan, Shaima Hassan, Esmaeil Khedmati-Morasae) • Training in **health coaching skills for health professionals** who work with people with progressive neurological conditions: A realist evaluation (Freya Davies, Fiona Wood, Alison Bullock, Carolyn Wallace, Adrian Edwards) • A qualitative study of **health-care experiences and challenges faced by ageing homebound adults** (Joyce M Cheng, George P Batten, Thomas Cornwell, Nengliang Yao) • **Patient involvement in interprofessional education**: A qualitative study yielding recommendations on incorporating the patient's perspective (Sjim Romme, Matthijs H Bosveld, Marloes A Van Bokhoven, Jascha De Nooijer, Hélène Van den Besselaar, Jerôme J J Van Dongen) • Engagement of community stakeholders to develop a framework to guide **research dissemination to communities** (Jennifer Cunningham-Erves, Tilicia Mayo-Gamble, Yolanda Vaughn, Jim Hawk, Mike Helms, Claudia Barajas, Yvonne Joosten)

BMJ Quality & Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality &Safety* has published a number of 'online first' articles, including: • Editorial: **Well spotted: but now you need to do something** (Richard Hamblin, Carl Shuker) • Differences in t**ransitional care processes** among high-performing and low-performing hospital-SNF pairs: a rapid ethnographic approach (Kirstin A Manges, Roman Ayele, Chelsea Leonard, Marcie Lee, Emily Galenbeck, Robert E Burke)

	• International recommendations for a **vascular access minimum dataset**: a Delphi consensus-building study (Jessica Schults, Tricia Kleidon, Vineet Chopra, Marie Cooke, Rebecca Paterson, Amanda J Ullman, Nicole Marsh, Gillian Ray-Barruel, Jocelyn Hill, İlker Devrim, Fredrik Hammarskjold, Mavilde L Pedreira, Sergio Bertoglio, Gail Egan, Olivier Mimoz, Ton van Boxtel, Michelle DeVries, M Magalhaes, C Hallum, S Oakley, C M Rickard)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-articles
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Effect of referral systems on **costs and outcomes after hip fracture surgery** in Taiwan (Bo-Lin Chiou, Yu-Fu Chen, Hong-Yaw Chen, Cheng-Yen Chen, Shu-Chuan Jennifer Yeh, Hon-Yi Shi)

Online resources

National COVID-19 Clinical Evidence Taskforce
https://covid19evidence.net.au/
The National COVID-19 Clinical Evidence Taskforce is a collaboration of peak health professional bodies across Australia whose members are providing clinical care to people with COVID-19. The taskforce is undertaking continuous evidence surveillance to identify and rapidly synthesise emerging research in order to provide national, **evidence-based guidelines and clinical flowcharts for the clinical care of people with COVID-19**. The guidelines address questions that are specific to managing COVID-19 and cover the full disease course across mild, moderate, severe and critical illness. These are 'living' guidelines, updated with new research in near real-time in order to give reliable, up-to-the minute advice to clinicians providing frontline care in this unprecedented global health crisis.

COVID-19 Critical Intelligence Unit
https://www.aci.health.nsw.gov.au/covid-19/critical-intelligence-unit
The Agency for Clinical Innovation (ACI) in New South Wales has developed this page summarising rapid, evidence-based advice during the COVID-19 pandemic. Its operations focus on systems intelligence, clinical intelligence and evidence integration. The content includes a daily evidence digest and evidence checks on a discrete topic or question relating to the current COVID-19 pandemic.

[*UK*] *NICE Guidelines and Quality Standards*
https://www.nice.org.uk/guidance
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- NICE Guideline NG59 ***Low back pain*** *and* ***sciatica*** *in over 16s: assessment and management*
  https://www.nice.org.uk/guidance/ng59
- NICE Guideline NG182 ***Insect bites*** *and stings:* ***antimicrobial prescribing***
  https://www.nice.org.uk/guidance/ng182