



On the Radar

Issue 349

27 November 2017

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On the Radar

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Consultation open: Colonoscopy Clinical Care Standard

<https://www.safetyandquality.gov.au/our-work/clinical-care-standards/current-consultations/>

In collaboration with consumers, clinicians, researchers and health organisations, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed a draft *Colonoscopy Clinical Care Standard*.

Clinical care standards can play an important role in guiding the delivery of appropriate care and reducing unwarranted variation, as they identify and define the care people should expect to be offered, regardless of where they are treated in Australia. They target areas of variation where improvement can be made.

The *national Safety and Quality Model for Colonoscopy Services in Australia (2017)* was developed by the Commission at the request of the Australian Government Department of Health. The model requires health services to demonstrate implementation of a Colonoscopy Clinical Care Standard, certification and recertification of proceduralists, and local monitoring of a succinct set of quality indicators.

The *Colonoscopy Clinical Care Standard* aligns with the National Safety and Quality Health Service (NSQHS) Standards and takes account of the colonoscopy certification and re-credentialing model for clinicians being developed by the clinical colleges and professional societies in Australia.

Consultation on the draft Colonoscopy Clinical Care Standard and associated resources is now open until **29 December 2017**. Submissions are requested via online survey or in writing.

To access the Colonoscopy Clinical Care Standard and the online survey see
<https://www.safetyandquality.gov.au/our-work/clinical-care-standards/current-consultations/>

Consultation paper – Patient safety and quality improvement in primary care – October 2017
<https://www.safetyandquality.gov.au/our-work/primary-health-care/>

The Australian Commission on Safety and Quality in Health Care is seeking feedback on patient safety and quality improvement in primary care. A consultation paper has been developed outlining the Commission’s approach to this work. The Commission is seeking feedback on its proposed strategies as well as feedback on other strategies, tools and resources that need to be developed to support improvements in patient safety and quality for primary care services.

The consultation process is open until Friday 22 **December**.

Section 7 of the consultation paper outlines a number of questions to guide your submission. Feedback will be collected via written submissions, either by post or email. Submissions can be sent to:

Patient safety and quality improvement in primary care
 Australian Commission on Safety and Quality in Health Care
 GPO Box 5480
 SYDNEY NSW 2001

Or emailed to: NSQHSSstandards@safetyandquality.gov.au

Journal articles

Fatigue and risk: are train drivers safer than doctors?

Greig P, Snow R
 BMJ. 2017;359;j5107.

Dangers of fatigue

Godlee F
 BMJ. 2017;359;j5294.

DOI	Greig and Snow https://dx.doi.org/10.1136/bmj.j5107 Godlee https://dx.doi.org/10.1136/bmj.j5294
Notes	<p>Editorial and article from the <i>BMJ</i> looking at the question of fatigue and its implication for safe health care. Greig and Snow make the following key points:</p> <ul style="list-style-type: none"> • Fatigue is a major risk factor for mistakes and poor decision making • Individual workers are very poor at assessing their own fatigue risk • Attitudes to breaks and long hours among healthcare workers would be considered unprofessional and illegal in other workplaces where safety is critical • No evidence shows that clinical workers are less able to withstand fatigue than those in other industries • You can assess and reduce your risk profile and support colleagues to do so. <p>In her editorial, Godlee comments that “Other safety critical industries, such as air and road transport, now have clear rules to safeguard against fatigue. Staff can’t opt out, and the rules take account of not only hours worked but the cumulative effect of patterns of work. Schedules and budgets have to take them into account. Not so in medicine.”</p>

A three-talk model for shared decision making: multistage consultation process
 Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, et al.
 BMJ. 2017;359:j4891.

DOI	https://dx.doi.org/10.1136/bmj.j4891
Notes	<p>Paper co-authored by many of the leading workers on the topic of shared decision making. In this paper they describe a revised model for shared decision making. The paper describes a ‘three-talk model’ of shared decision making. This revised model has “team talk,” “option talk,” and “decision talk” components in a process of collaboration and deliberation.</p> <ul style="list-style-type: none"> • Team talk places emphasis on the need to provide support to patients when they are made aware of choices, and to elicit their goals as a means of guiding decision making processes. • Option talk refers to the task of comparing alternatives, using risk communication principles. • Decision talk refers to the task of arriving at decisions that reflect the informed preferences of patients, guided by the experience and expertise of health professionals.

For information on the Commission’s work on shared decision making, see <https://www.safetyandquality.gov.au/our-work/shared-decision-making/>

Safe handover

Merten H, van Galen LS, Wagner C
 BMJ. 2017;359:j4328.

DOI	https://dx.doi.org/10.1136/bmj.j4328
Notes	<p>Handovers/handoffs happen frequently – millions of times a day globally – and are known as a source of potential error, especially communication errors. This piece summarises current thinking and makes the following key points:</p> <ul style="list-style-type: none"> • Information shared during clinical handover includes, as a minimum, the patient’s current health status, medications, and treatment plans as well as advance directives and any important changes in the patient’s status • Tools and handover structures have been shown to improve the quality of handovers • Involving patients and carers in handovers—including scheduling a timely discharge conversation to discuss aspects of their admission and follow-up plan that includes a personalised discharge letter—is of great value. <p>However, handovers are just one point in the continuum of communications (and the associated skills of information acquisition, synthesis, critical appraisal and dissemination) that make up the delivery of health care. Health care is an activity that is intrinsically about information and its use and transfer.</p>

For information on the Commission’s work on clinical communications, including clinical handover, see <https://www.safetyandquality.gov.au/our-work/clinical-communications/>

COPD-X Australian and New Zealand guidelines for the diagnosis and management of chronic obstructive pulmonary disease: 2017 update

Yang IA, Brown JL, Johnson G, Jenkins S, McDonald CF, McDonald VM, et al
 Medical Journal of Australia. 2017;207(10):436-42.

Patients with thunderstorm asthma or severe asthma in Melbourne: a comparison

Sutherland MFS, Le Portelli E, Collins AL, Rahman MA, McDonald CF
 Medical Journal of Australia. 2017;207(10):434-5.

The future of health care in Australia

King C
 Medical Journal of Australia. 2017;207(10):415-6.

DOI	Yang et al https://dx.doi.org/10.5694/mja17.00686 Sutherland et al https://dx.doi.org/10.5694/mja17.00780 King https://dx.doi.org/10.5694/mja17.00739
Notes	This week's <i>MJA</i> includes a summary of the updated Australian and New Zealand COPD guidelines (COPD-X), which continue to recommend both pharmacological and non-pharmacological management, with a key role for exercise, pulmonary rehabilitation and smoking cessation. A small-sample observational study compared patients with outpatient follow-up after the Melbourne 'thunderstorm asthma' event with severe asthma patients and found a higher incidence of rye grass pollen allergy in the thunderstorm asthma patients. The Hon. Catherine King MP describes the opposition's policy approach to the future of health care, following a similar article by the Minister, the Hon. Greg Hunt MP, in a previous issue.

Sociodemographic variations in the amount, duration and cost of potentially preventable hospitalisation for chronic conditions among Aboriginal and non-Aboriginal Australians: a period prevalence study of linked public hospital data

Banham D, Chen T, Karnon J, Brown A, Lynch J
 BMJ Open. 2017;7(10).

DOI	https://dx.doi.org/10.1136/bmjopen-2017-017331
Notes	Paper reporting on a study that sought to examine disparities in rates, length of stay (LOS) and hospital costs of potentially preventable hospitalisations (PPH) for selected chronic conditions among Aboriginal and non-Aboriginal South Australians along with associations with area-level socioeconomic disadvantage and remoteness. The study found that Aboriginal South Australians experienced higher risk of index chronic PPH compared with non-Aboriginals (11.5 and 6.2 per 1000 persons per year, respectively) and at younger ages (median age 48 vs 70 years). Further, once hospitalised, Aboriginal people experienced more chronic PPH events, longer total LOS with higher costs than non-Aboriginal people (2.6 vs 1.9 PPH per person; 11.7 vs 9.0 days LOS; at \$A17 928 vs \$A11 515, respectively). These and other results led to the conclusion that "Aboriginal people's heightened risk of chronic PPH resulted in more time in hospital and greater cost. Systematic disparities in chronic PPH by Aboriginality, area disadvantage and remoteness highlight the need for improved uptake of effective primary care."

Savings from reducing low-value general surgical interventions
 Malik HT, Marti J, Darzi A, Mossialos E
 British Journal of Surgery. 2017 [epub].

The high costs of unnecessary care
 Carroll AE

Journal of the American Medical Association. 2017;318(18):1748-9.

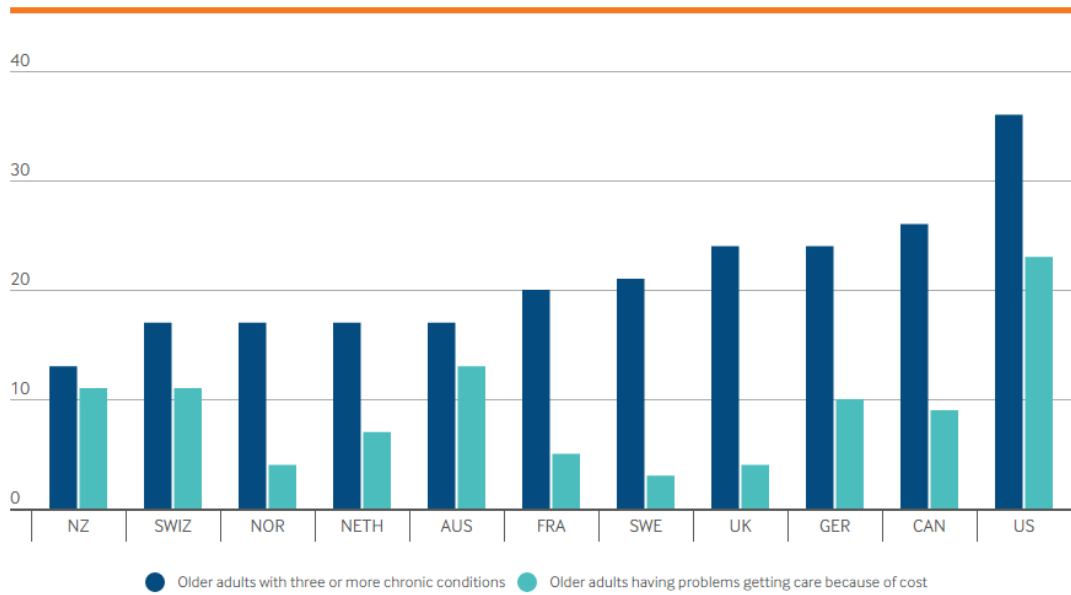
DOI	Malik et al https://dx.doi.org/10.1002/bjs.10719 Carroll https://dx.doi.org/10.1001/jama.2017.16193
Notes	<p>Questions of value and waste are being posed through programs such as Choosing Wisely. These are sometimes countered with concerns about ‘rationing’ or reducing choice. Malik et al reports on a British study that sought to identify surgical interventions that deliver little benefit to patients and then assess the costs (and potential savings) of these interventions in the English National Health Service. The study identified 71 low-value general surgical procedures of which “five were of high frequency and high cost (highest impact), 22 were of high cost and low frequency, 23 were of low cost and high frequency, and 21 were of low cost and low frequency (lowest impact). The five highest impact interventions included inguinal hernia repair in minimally symptomatic patients, inappropriate gastroscopy, interval cholecystectomy, CT to diagnose appendicitis and routine endoscopy in those who had CT-confirmed diverticulitis. The estimated cost of these was more €153 million per annum.</p> <p>The authors are not advocating the banning of procedures, as they observe “There are pitfalls with labelling a procedure as low value, as clinical context dictates value.” They go on to note that “It is important that stopping low-value interventions happens only in correct clinical populations where the intervention is of little benefit. The challenge lies in identifying patients for whom the clinical context dictates the intervention as low value.”</p> <p>Carroll’s item in <i>JAMA</i> is an indication of how these discussions of value are making their way into the medical mainstream. This short piece summarises some of the recent literature and key issues, including that unnecessary care is not only expensive, exposes patients to unnecessary harm and means other patients may not be receiving care they need. Carroll concludes with some suggestions “We can educate the public better on the issue of low-value care, stressing the harms, both financial and health-related. We can minimize the financial incentives of providing unnecessary treatments, by identifying conflicts of interest and making hospitals and physicians more responsible for some of the decisions they make. We could also push for insurance reform that refuses to pay for care that’s not needed, making everyone think twice before employing it. It will likely take changes on all these fronts to make a real difference.”</p>

Older Americans Were Sicker And Faced More Financial Barriers To Health Care Than Counterparts In Other Countries

Osborn R, Doty MM, Moulds D, Sarnak DO, Shah A
 Health Affairs. 2017 [epub].

DOI	https://dx.doi.org/10.1377/hlthaff.2017.1048
Notes	<p>Each year the (US) Commonwealth Fund surveys various aspects of health care systems in the US and a group of comparable countries, including Australia. Each year they release the findings in conjunction with an article in <i>Health Affairs</i>. This article reports on the most recent survey that looked at issues of chronic disease and healthcare cost for older adults.</p> <p>The authors report that from the eleven countries surveyed (Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States) that those in the USA “are sicker than their counterparts in 10 other high-income countries and face greater financial barriers to health care, despite the universal coverage that Medicare provides. Across all the countries, few elderly adults discuss mental health concerns with their primary care providers. Moreover, nearly a quarter are considered “high need” — meaning they have three or more chronic conditions or require help with basic tasks of daily living.”</p> <p>The key findings include:</p> <ul style="list-style-type: none"> • In all 11 countries, at least one of eight older adults reported having three or more chronic conditions, with rates ranging from 13 percent in New Zealand to 36 percent in the USA (17% in Australia) • US seniors stand out for the financial barriers they experience in getting care. Nearly one-quarter (23%) of older adults in the U.S. said that, in the past year, they had not visited a doctor when sick, had skipped a recommended test or treatment, had not filled a prescription, or had skipped medication doses because of the cost. Five percent or fewer of respondents in France, Norway, Sweden, and the U.K. reported these cost barriers (13% in Australia) • USA and Switzerland are outliers on out-of-pocket expenses, with nearly 22% of US respondents and 31% of Swiss respondents reporting they had spent \$2,000 or more for medical care in the past year. In all other countries, fewer than 10 percent of older adults spent that much (9% in Australia). • Few older adults in any of the countries surveyed reported discussing with their clinicians feelings of stress or anxiety, even though asking such questions can help flag mental health concerns. Rates ranged from 32% in Australia to 9% in Sweden. • Across all 11 countries, at least one of four older adults are categorized as “high need” — meaning they have multiple chronic conditions or trouble performing activities of daily living, like cooking or shopping. The U.S. and Australia have significantly higher proportions of high-need elderly adults (43% and 39%, respectively). • High-need older adults in the U.S. struggle with costs. Nearly one-third (31%) skip care because of costs, compared to only 2 percent in Sweden (19% in Australia).

U.S. Seniors More Likely to Be Sick and Have Trouble Affording Care Than Those in Peer Nations



Notes: Chronic conditions: joint pain or arthritis; asthma or chronic lung disease; cancer; diabetes; heart disease, including heart attack; hypertension or high blood pressure, and/or stroke. Cost-related access problem in past year: 1) Did not see doctor when sick; 2) skipped medical test or treatment recommended by a doctor; and/or 3) did not fill prescription or skipped doses because of cost.

Source: 2017 Commonwealth Fund International Health Policy Survey of Older Adults.

In these surveys Australia has tended to poll quite well on outcomes and services but less well on affordability (out of pocket costs)) and a number of other aspects. Additional information is available at the Commonwealth Fund's website at <https://www.commonwealthfund.org/publications/in-the-literature/2017/nov/older-americans-sicker-and-faced-more-financial-barriers-to-care>

BMJ Quality & Safety

December 2017 - Volume 26 - 12

URL	https://qualitysafety.bmj.com/content/26/12
Notes	<p>A new issue of <i>BMJ Quality and Safety</i> has been published. Many of the papers in this issue have been referred to in previous editions of <i>On the Radar</i> (when they were released online). Articles in this issue of <i>BMJ Quality and Safety</i> include:</p> <ul style="list-style-type: none"> • Editorial: Remediation and rehabilitation programmes for health professionals: challenges for the future (François Goulet, Johanne Thiffault, Roger Ladouceur) • Editorial: Handoffs: what's good for residents is good for nurses...so what's next? (Rebecca R Kitzmiller, Sim B Sitkin, Arpana R Vidyarthi) • Editorial: Compassionate care: constitution, culture or coping? (Elaine Maxwell) • Effects of the I-PASS Nursing Handoff Bundle on communication quality and workflow (Amy J Starmer, Kumiko O Schnock, Aimee Lyons, Rebecca S Hehn, Dionne A Graham, Carol Keohane, Christopher P Landrigan) • Patients' and providers' perceptions of the preventability of hospital readmission: a prospective, observational study in four European countries (Louise S van Galen, Mikkel Brabrand, Tim Cooksley, Peter M van de Ven, Hanneke Merten, Ralph KL So, Loes van Hooff, Harm R Haak, Rachel M Kidney, Christian H Nickel, John TY Soong, Immo Weichert, Mark HH

	<p>Kramer, Christian P Subbe, Prabath WB Nanayakkara On behalf of the Safer@home consortium)</p> <ul style="list-style-type: none"> • Optimising impact and sustainability: a qualitative process evaluation of a complex intervention targeted at compassionate care (Jackie Bridges, Carl May, Alison Fuller, Peter Griffiths, Wendy Wigley, Lisa Gould, Hannah Barker, Paula Libberton) • How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England (Lorelei Jones, Linda Pomeroy, Glenn Robert, Susan Burnett, Janet E Anderson, Naomi J Fulop) • Controlled trial to improve resident sign-out in a medical intensive care unit (Rahul Nanchal, Brian Aebly, Gabrielle Graves, Jonathon Truwit, Gagan Kumar, Amit Taneja, Gaurav Dagar, Jeanette Graf, Erin Hubertz, Vijaya Ramalingam, Kathlyn E Fletcher) • A randomised controlled trial assessing the efficacy of an electronic discharge communication tool for preventing death or hospital readmission (Maria J Santana, Jayna Holroyd-Leduc, Danielle A Southern, Ward W Flemons, Maeve O’Beirne, Michael D Hill, Alan J Forster, Deborah E White, William A. Ghali the e-DCT Team) • Getting back on track: a systematic review of the outcomes of remediation and rehabilitation programmes for healthcare professionals with performance concerns (Jan-Willem Weenink, Rudolf B Kool, Ronald H Bartels, Gert P Westert) • Framework for direct observation of performance and safety in healthcare (Ken Catchpole, David M Neyens, James Abernathy, David Allison, Anjali Joseph, Scott T Reeves) • Compassionate care: not easy, not free, not only nurses (Roberta Bivins, Stephanie Tierney, Kate Seers)
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American Journal of Medical Quality

Volume: 32, Number: 6 (November/December 2017)

URL	https://journals.sagepub.com/toc/ajmb/32/6
Notes	<p>A new issue of the <i>American Journal of Medical Quality</i> has been published. Articles in this issue of <i>American Journal of Medical Quality</i> include:</p> <ul style="list-style-type: none"> • Editorial: How Can We Effectively Engage Physicians in the Deprescribing Process? (Laurence Djatche, David Singer, Arianna Heyer, Marco Lombardi, Stefano Del Canale, and Vittorio Maio) • The Link Between Clinically Validated Patient Safety Indicators and Clinical Outcomes (Darrell M Gray, Jennifer L Hefner, Michelle C Nguyen, Daniel Eiferman, and Susan D Moffatt-Bruce) • Impact of Hospital-Wide Comprehensive Pain Management Initiatives (Paula E Lester, Janet Shehata, Melissa Fazzari, and Shahidul Islam) • Eliminating Disparities in Asthma Care: Identifying Broad Challenges in Quality Improvement (Joseph P Anarella, Victoria L Wagner, Susan G McCauley, Jennifer B Mane, and Patricia A Waniewski) • Correlations Among Hospital Quality Measures: What “Hospital Compare” Data Tell Us (Jianhui Hu, Jack Jordan, Ilan Rubinfeld, Michelle Schreiber, Brian Waterman, and David Nerenz) • Complication Rates, Hospital Size, and Bias in the CMS Hospital-Acquired Condition Reduction Program (Lane Koenig, Samuel A Soltoff, Berna Demiralp, Akinluwa A Demehin, Nancy E Foster, Caroline Rossi)

	<p>Steinberg, Christopher Vaz, Scott Wetzel, and Susan Xu)</p> <ul style="list-style-type: none"> • Improving Physician Communication With Patients as Measured by HCAHPS Using a Standardized Communication Model (Devin J Horton, P M Yarbrough, N Wanner, R D Murphy, P V Kukhareva, and K Kawamoto) • Education for the Next Frontier in Patient Safety: A Longitudinal Resident Curriculum on Diagnostic Error (Emily Ruedinger, Maren Olson, Justin Yee, Emily Borman-Shoap, and Andrew P J Olson) • Reputation and the Best Hospital Rankings: What Does It Really Mean? (Santino Cua, Susan Moffatt-Bruce, and Susan White) • Is Telemetry Monitoring Useful in Patients Admitted With Suspected Acute Coronary Syndrome? (Jack Perkins, Naveen K Voore, Jaideep Patel, Sathish Sanna, Edana Mann, Sammy Zakaria, and Aysegul Gozu) • Patient and Provider Characteristics Associated With Optimal Post-Fracture Osteoporosis Management (Natalie N Boytsov, Albert G Crawford, Leslie Ann Hazel-Fernandez, John F McAna, Radhika Nair, Vishal Saundankar, Stefan Varga, and Fan Emily Yang) • A Novel Approach to Improving Patient Experience in Orthopedics (Spencer M Stein, Sarav S Shah, Alanna Carcich, Marlena McGill, Isaac Gammal, Michael Langino, and Thomas Mauri) • Cost-Effectiveness of Behavior Activation Versus Supportive Therapy on Adherence to Eye Exams in Older African Americans With Diabetes (David Winters, Robin Casten, Barry Rovner, Ann Murchison, Benjamin E Leiby, Julia A Haller, Lisa Hark, David M Weiss, and Laura T Pizzi) • Blood Management Strategies to Reduce Transfusions After Elective Lower-Extremity Joint Arthroplasty Surgeries: One Tertiary Care Hospital’s Early Experience With an Alternative Payment Model—a Total Joint “Bundle” (Ankit Kansagra, C Andrzejewski, R Krushell, A Lehman, J Greenbaum, P Visintainer, J McGirr, K Mahoney, D Cloutier, A Ehresman, and M S Stefan) • Commentary on “The Link Between Clinically Validated Patient Safety Indicators and Clinical Outcomes” (John R Griffith) • Reducing Time to Internal Medicine Consultation in the ED of a Community-Based Hospital: A Commentary on a Quality Improvement Initiative (Melissa Di Santo, Elaina Orlando, and Madelyn P Law) • Closing the Gap Between Health Care Worker and Patient Safety (Leah Binder and Ben Favret) • Exploring the Feasibility of Incorporating Sexual Education Into Routine Adolescent Office Visits (Holly A Rankin, Alisa LoSasso, and Beth I Schwartz)
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International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access?papetoc
Notes	<p><i>International Journal for Quality in Health Care</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Factors influencing the activation of the rapid response system for clinically deteriorating patients by frontline ward clinicians: a systematic review (Wei Ling Chua; Min Ting Alicia See; Helena Legio-Quigley; Daryl Jones; Augustine Tee; Sok Ying Liaw) • Barriers and facilitators related to the implementation of a physiological track and trigger system: A systematic review of the qualitative evidence (Fergal Connolly; Dara Byrne; Sinéad Lydon; Chloe Walsh; Paul O’Connor)

	<ul style="list-style-type: none"> • Scaling up improvements more quickly and effectively (John Øvretveit; Lynn Garofalo; Brian Mittman) • Evaluating quality indicators of tertiary care hospitals for trauma care in Japan (Shinji Nakahara; Tetsuya Sakamoto; Takashi Fujita; Yasuyuki Uchida; Yoichi Katayama; Seizan Tanabe Yasuhiro Yamamoto) • Organizing and implementing a multidisciplinary fast track oncology clinic (Y L Basta; K M A J Tytgat; H H Greuter; J H G Klinkenbijn; P Fockens; J Strikwerda)
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Online resources

Caring for Cognitive Impairment campaign website

<http://cognitivecare.gov.au/>

The updated Caring for Cognitive Impairment campaign website has been released by the Australian Commission on Safety and Quality in Health Care.

The Caring for Cognitive Impairment campaign is about providing better outcomes and experiences for patients with cognitive impairment in hospitals, and for their loved ones and staff who care for them. By improving our knowledge and care practices, we can reduce the risk of harm in hospital.

The campaign website has a wealth of information, tools, stories and resources aimed at those working in hospitals caring for people with cognitive impairment. The website will also help hospitals prepare for the new cognitive impairment items in the *National Safety and Quality Health Service Standards*

(second edition). See <http://cognitivecare.gov.au/about/the-nsqhc-standards/>

Anyone interested in cognitive impairment are encouraged to commit to caring for cognitive impairment. There is a role for everyone: people living with cognitive impairment, carers, family members and other support people, doctors, nurses, allied health professionals, health service managers, and care and support staff.

Medical Devices Safety Update

<https://www.tga.gov.au/publication-issue/medical-devices-safety-update-volume-5-number-6-november-2017>

Volume 5, Number 6, November 2017

The Therapeutic Goods Administration (TGA) has released the latest edition of its medical device safety bulletin. Topics covered in this issue include:

- **Button battery safety** – TGA has contacted 175 medical device sponsors regarding potential safety issues associated with the use of button batteries
- Patient education vital for **infusor use** – a range of factors can influence the infusion and flow rates encountered when using elastometric infusors
- **Gas cylinder pressure regulators** warning – the industry body covering hospital gas suppliers has warned about an issue with some gas cylinder pressure regulators
- **Recent safety alerts** – TGA safety alerts relating to medical devices published since the last edition of *Medical Devices Safety Update*.

National Stroke Audit

<https://informme.org.au/en/stroke-data/Acute-audits>

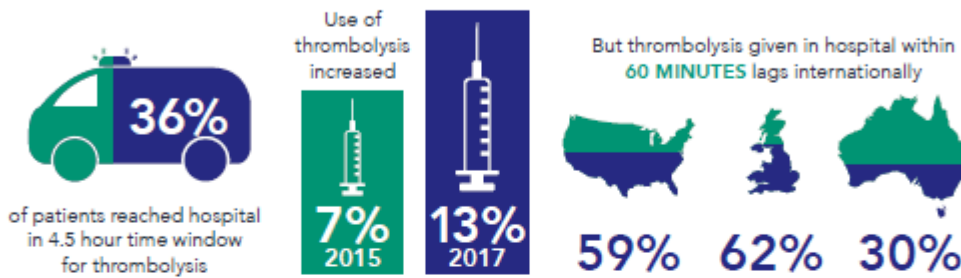
The Stroke Foundation has released the *2017 Acute Stroke Audit*, which measures the delivery and adherence to evidence-based care outlined in the Stroke Foundation's *Clinical Guidelines for Stroke Management* and the Australian Commission on Safety and Quality in Health Care's *Acute Stroke Clinical Care Standard*.

Clinicians, healthcare administrators and governments can use the data in this report to review services and clinical care in order to improve the quality of stroke management across Australia.

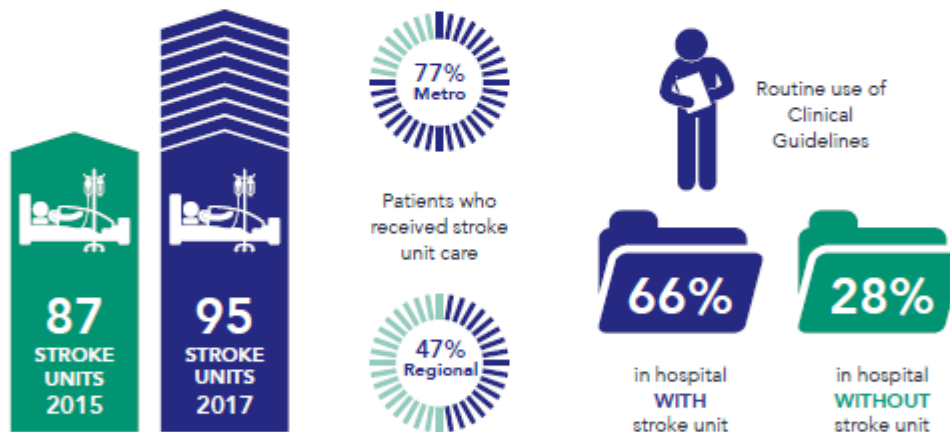
At a glance

- > 127 Hospitals
- > 31,952 Acute stroke admissions

Time critical stroke therapy



Stroke unit care



More patient care needed



For more information on the Commission's work on clinical care standards, including the *Acute Stroke Clinical Care Standard*, see <https://www.safetyandquality.gov.au/our-work/clinical-care-standards/>

[USA] Effective Health Care Program reports

<https://effectivehealthcare.ahrq.gov/>

The US Agency for Healthcare Research and Quality (AHRQ) has an Effective Health Care (EHC) Program. The EHC has released the following final reports and updates:

- *Diagnostic Accuracy of Screening and Treatment of **Post-Acute Coronary Syndrome Depression**: A Systematic Review*

<https://effectivehealthcare.ahrq.gov/topics/acs-depression/research-review-final>

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