AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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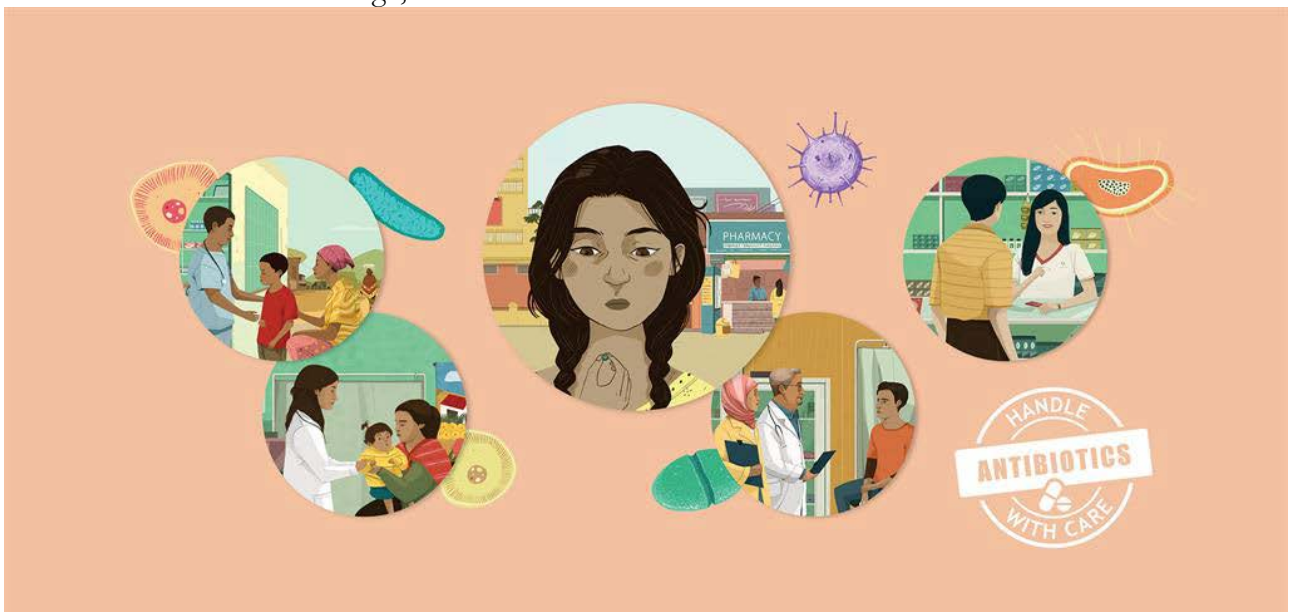
Antibiotic Awareness Week 2018
https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/antibiotic-awareness-week/
World Antibiotic Awareness Week occurs annually in November. It aims to draw attention to the role of effective use of antibiotics in preventing and containing antimicrobial resistance (AMR). Antibiotics are a type of antimicrobial. Antibiotic Awareness Week is a key initiative to promote the correct use of antibiotics to contribute to the avoidance of further emergence and spread of AMR. AMR is already affecting the care of patients now and current trends indicate this will have an increasing impact over time.

Antibiotic Awareness Week provides an opportunity to highlight the problem of antimicrobial resistance and to promote the safe and judicious use of antimicrobials. The resources below have been developed to assist hospitals and health service organisations in running activities and events in the lead up to and during Antibiotic Awareness Week.

National Safety and Quality Health Service (NSQHS) Standards– Antimicrobial Stewardship
https://www.nationalstandards.safetyandquality.gov.au/3.-healthcare-associated-infection/antimicrobial-stewardship/antimicrobial-stewardship
Assessment to the second edition of the National Safety and Quality Health Service (NSQHS) Standards will commence from 1 January 2019. Health service organisations will be informed of the transition arrangements well in advance of implementation. There is updated information on the Antimicrobial Stewardship standard on the Commission's new NSQHS Standards microsite.

WHO World Antibiotic Awareness Week
https://www.who.int/who-campaigns/world-antibiotic-awareness-week
The World Health Organization's World Antibiotic Awareness Week website has information and resources about antibiotic usage, awareness and the Antibiotic Awareness Week.



European Antibiotic Awareness
https://antibiotic.ecdc.europa.eu/en/infographics-about-antibiotic-stewardship-programmes
The European Centre for Disease Prevention and Control (ECDC) website also has information and resources for antibiotic awareness, including links to various national campaigns in various European countries.

33 000 people die every year due to infections with antibiotic-resistant bacteria
https://ecdc.europa.eu/en/news-events/33000-people-die-every-year-due-infections-antibiotic-resistant-bacteria
This ECDC study estimates that about 33 000 people die each year in countries of the EU and European Economic Area (EEA) as a direct consequence of an infection due to bacteria resistant to antibiotics and that the burden of these infections is comparable to that of influenza, tuberculosis and HIV/AIDS combined. It also explains that 75% of the burden of disease is due to healthcare-associated infections (HAIs) and that reducing this through adequate infection prevention and control measures, as well as antibiotic stewardship, could be an achievable goal in healthcare settings.

Public Health England – Keep antibiotics working
https://campaignresources.phe.gov.uk/resources/campaigns/58-keep-antibiotics-working/
Public Health England has developed this website that includes resources for the 'Keep antibiotics working' campaign. The resources include patient guides which are helpful tools for clinicians to use in consultations with patients who do not require an antibiotic prescription for their indication they include respiratory tract infections and urinary tract infections.

English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) Report 2018
Public Health England
London: Public Health England; 2018. p. 147.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/749747/ESPAUR_2018_report.pdf
The ESPAUR report includes national data on antibiotic prescribing and resistance, and hospital antimicrobial stewardship implementation. Antibiotic use in the primary care sector accounted for 81% of total use. Consequently many of the strategies detailed are targeted for primary care.

NICE Antimicrobial prescribing guidelines
https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/antimicrobial-prescribing-guidelines
The UK's National Institute for Health and Care Excellence (NICE) has developed clinical syndrome specific guidance and advice to help slow the development of antimicrobial resistance.

National Antimicrobial Resistance and Stewardship Forum
https://www.webevent.com.au/amrams/
The 2018 National Antimicrobial Resistance and Stewardship Forum was hosted by the National Centre for Antimicrobial Stewardship (Department of Medicine and Doherty Institute, University of Melbourne) and Safer Care Victoria (Department of Health and Human Services, Victoria). Some of the presentations are available online.

NSW Clinical Excellence Commission Antibiotic Awareness Week
https://www.cec.health.nsw.gov.au/patient-safety-programs/medication-safety/antimicrobial-stewardship/quah/antibiotic-awareness-week
The CEC held a number of webinars that are now available from their website. Topics included:

- Implementing AMS In the operating theatre
- AMS in the Emergency Department
- AMS strategies in the ICU.

Antimicrobial prescribing in regional and remote hospitals
https://www.doctorportal.com.au/mjainsight/2018/43/antimicrobial-prescribing-in-regional-and-remote-hospitals
Dr Arjun Rajkhowa from the National Centre for Antimicrobial Stewardship considers the issues influencing antimicrobial prescribing in regional and remote hospitals in Australia.

Purple Pen Podcast – Live from the Antibiotic Allergy in Practice Workshop
https://www.purplepenpodcast.com/home/2018/11/3/ppp062-live-from-the-antibiotic-allergy-in-practice-workshop-2018
Dr Ar Kar Aung, Infectious Diseases physician from The Alfred Hospital discusses the classification and detection of antibiotic adverse reactions. Dr Michelle Goh, Dermatologist at Alfred Health, Austin Health and Peter MacCallum regarding characterising allergy phenotypes. Dr Natasha Holmes, ID and Antibiotic Allergy Physician, on drug induced acute interstitial nephritis. Karen Urbancic, ID Pharmacist at Austin Health and the National Centre for Antimicrobial Stewardship, on the practicalities of desensitisation protocols.

Antimicrobial prescribing practice in Australian hospitals: Results of the 2017 Hospital National Antimicrobial Prescribing Survey
National Centre for Antimicrobial Stewardship and Australian Commission on Safety and Quality in Health Care.
Sydney: ACSQHC; 2018. p. 41.
https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/naps-2/?section=4
The *Antimicrobial prescribing practice in Australian hospitals: Results of the 2017 Hospital National Antimicrobial Prescribing Survey* indicates that around one-third of antimicrobial prescriptions in Australian hospitals were not compliant with treatment guidelines, and almost **1 in 4 antimicrobial prescriptions were assessed as inappropriate**.

Surgical Prophylaxis
https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/antimicrobial-stewardship/surgical-antimicrobial-prophylaxis/
The Hospital National Antimicrobial Prescribing Survey (NAPS) is a voluntary survey that enables Australian hospitals to assess the appropriateness of their antimicrobial use. This data can also be aggregated and analysed to provide an overall picture of the appropriateness of antibiotic used in participating hospitals.

In 2017, the Hospital NAPS showed that, on average, 30.5% of surgical antimicrobial prophylaxis prescriptions extended 24 hours beyond the time of surgery (n = 26,227 prescriptions). This is an improvement compared with the first Hospital NAPS in 2013 (n = 12,800 prescriptions), when the overall proportion of surgical prophylaxis given for greater than 24 hours was 41.8%.

The Australian Commission on Safety and Quality in Health Care has convened a Surgical Antimicrobial Prophylaxis Working Group with representatives from the Royal Australasian College of Surgeons; the Australian and New Zealand College of Anaesthetists; the Australian College of Perioperative Nursing; the Australian Private Hospitals Association; the National Centre for Antimicrobial Stewardship; and state and territory health department representatives. The group is supporting the Commission in the development of a range of resources to improve the prescribing of surgical antimicrobial prophylaxis.

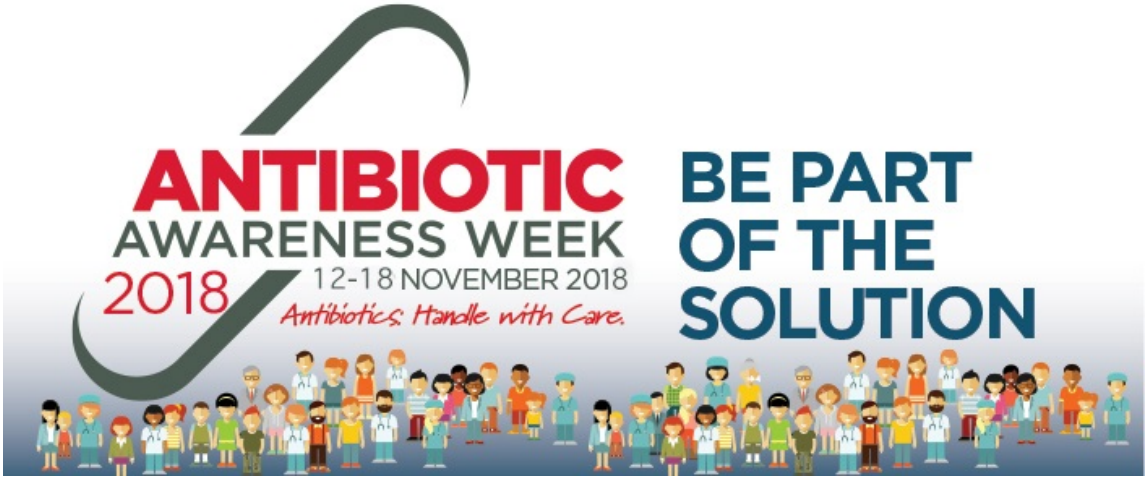
Antimicrobial Stewardship Indicators
https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/ams-and-hai-resources-and-links/
These indicators were developed in consultation with the Australian Commission on Safety and Quality in Health Care's Antimicrobial Stewardship Advisory Committee and reviewed by a range of hospitals across Australia prior to endorsement by the Commission's Inter-Jurisdictional Committee. They are based on the Transatlantic Taskforce on Antimicrobial Resistance (TATFAR) indicators which were developed to support a standardised methodology for assessing AMS programs.

While the suite comprises 26 indicators which describe a range of characteristics considered necessary for an effective AMS program, they are not mandatory and aim to complement local indicators for AMS. The indicators are intended to support health service organisations with implementation of initiatives to meet the National Safety and Quality Health Service (NSQHS) Standards Preventing and Controlling Healthcare-Associated Infections Standard.

Antibiotic resistance: Worldwide threat to human health
https://www.news.com.au/lifestyle/health/health-problems/antibiotic-resistance-worldwide-threat-to-human-health/news-story/
Professor Chris Del Mar drew attention to many of the misconceptions regarding antibiotic use and their effectiveness in this news piece For example, he noted that antibiotics for a middle ear infection may only shorten the infection for half a day.

Antibiotics don't cure colds: Calls for prescription crackdown
https://www.smh.com.au/healthcare/antibiotics-don-t-cure-colds-calls-for-prescription-crackdown-20180904-p501pi.html
The national drug utilisation sub-committee has recommended that health officials consider removing prescription repeats for oral antibiotics and also reduce the expiry of these prescriptions to less than 12 months (with suggested alternatives anywhere between two weeks and three months).

Antibiotics and Childhood Obesity
https://www.independent.co.uk/news/health/antibiotic-obesity-children-antacid-weight-loss-child-gut-bacteria-microbes-bmj-a8609436.html
Recent research has emerged assessing the impact of antibiotics on the microbiome of the gut and the potential link with childhood obesity.



Journal articles

Endemic unprofessional behaviour in health care: the mandate for a change in approach
Westbrook J, Sunderland N, Atkinson V, Jones C, Braithwaite J
Medical Journal of Australia. 2018;209(9):380-1.

DOI	https://doi.org/10.5694/mja17.01261
Notes	Unprofessional behaviours have been in the spotlight of late. Indeed, the authors of this piece argue that it is so pervasive "in the Australian health care system that it could be considered endemic." They go on to observe that "**Bullying, discrimination and harassment are just the tip of the iceberg**. Unprofessional or disruptive behaviour encompasses a wide spectrum that includes conduct that more subtly interferes with team functioning, such as poor or ambiguous communication, passive aggression, lack of responsiveness, public criticism of colleagues, and humour at others' expense." These less apparent behaviours can still be incredibly damaging and pose a safety and quality risk to those working in and being cared for in such an environment. In the piece, existing interventions are discussed and generally found to be lacking. **Professional accountability** programs and the need for **culture change** are seen as the foundation of a safe and sustainable health system.

Updated clinical practice guidelines on pregnancy care
Homer CSE, Oats J, Middleton P, Ramson J, Diplock S
Medical Journal of Australia. 2018;209(9):409-12.

DOI	https://doi.org/10.5694/mja18.00286
Notes	The latest issue of the Medical Journal of Australia has this updated clinical practice guideline summary. The updated guidelines include the following key changes to practice: • **recommend routine testing for hepatitis C** at the first antenatal visit; • **recommend against routine testing for vitamin D** status in the absence of a specific indication; • **recommend discussing weight change, diet and physical activity** with all pregnant women; and • **recommend offering** pregnant women the opportunity to be **weighed at every antenatal visit** and encouraging women to **self-monitor weight** gain. This guideline summary outlines the process of reviewing and updating the guidelines and provides an overview of topics where new recommendations will lead to a change in practice. The full guidelines are at www.health.gov.au/pregnancycareguidelines

Why Doctors Hate Their Computers
Gawande A
The New Yorker. 2018 November 12.

Getting Rid of Stupid Stuff
Ashton M
New England Journal of Medicine. 2018;379(19):1789-91.

URL	Gawande https://www.newyorker.com/magazine/2018/11/12/why-doctors-hate-their-computers Ashton https://doi.org/10.1056/NEJMp1809698
Notes	This latest piece by Atul Gawande in *The New Yorker* provides some useful insights into the (over)development of the systems we work with and how the utility and functionality can diminish and foster resistance. These views have implication for clinical systems and electronic health records. One of the more pertinent observations is that such systems are not necessarily for or about the clinicians but rather the patient who is the subject and object of the system. It is somewhat analogous to the issue of who we design and build health facilities for – those who work in them every day or the patients who come there (more or less) occasionally to be treated. Ashton's piece in the *New England Journal of Medicine* is somewhat related as it picks up on something Gawande discusses, the tweaking or customisation of computerised systems in health systems. In this case, it was the 'getting rid of stupid stuff' that clinicians felt was redundant, wasted their time or was otherwise unnecessary. Of course, what is 'stupid stuff' may depend on your perspective. Those seeking to standardise systems for consistency, for example, for support and maintenance reasons and to ensure that new/agency staff to not have to learn variations may not always welcome such variation. Conversely, such changes may indeed create a better system that could (ideally) also be communicated to other users of similar systems.

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

Defining minimum necessary anticoagulation-related communication at discharge: Consensus of the Care Transitions Task Force of the New York State Anticoagulation Coalition
Triller D, Myrka A, Gassler J, Rudd K, Meek P, Kouides P, et al.
Joint Commission Journal on Quality and Patient Safety. 2018;44(11):630-40.

DOI	https://doi.org/10.1016/j.jcjq.2018.04.015
Notes	Transitions of care are recognised as having the potential for miscommunication and error. Some patients are more vulnerable, including those on high risk medicines, such as anticoagulants. This article is the outcome of a task force that the New York State Anticoagulation Coalition convened to develop a consensus list of requisite data elements (RDEs) that should accompany all anticoagulated patients undergoing care transitions. The panel reached consensus on a list of 15 RDEs for anticoagulation communication at discharge (the ACDC List). The ACDC List identifies specific pieces of clinical information that a panel of anticoagulant experts agree should be communicated to downstream providers for all anticoagulated patients undergoing care transitions. The elements encompassed a range of factors, including drug use and indications, previous exposure and duration of therapy, recent drug exposure and laboratory results and expectations for subsequent administration, therapy goals, patient education and comprehension, and expectations for clinical management. Twelve of the elements are applicable to any anticoagulant, and three are specific to warfarin.

Pediatric Quality & Safety
Vol. 3, No. 5, September/October 2018

URL	https://journals.lww.com/pqs/toc/2018/09000
Notes	*Pediatric Quality & Safety* has released a new issue. Papers in this issue of *Pediatric Quality & Safety* include: • Monitoring of **Sugammadex Dosing** at a Large Tertiary Care Pediatric Hospital (Syed, Faizaan; Trifa, Mehdi; Uffman, J. C.; Tumin, D.; Tobias, J. D.) • Multi-modal Educational Curriculum to Improve **Richmond Agitation-sedation Scale** Inter-rater Reliability in Pediatric Patients (Kihlstrom, Margaret J.; Edge, A. P.; Cherry, K. M.; Zarick, P. J.; Beck, S. D.; Boyd, J. M.) • Improving **Human Papilloma Virus Vaccination** Rates at an Urban Pediatric Primary Care Center (Brodie, Nicola; McPeak, Katie E.) • Identifying Hesitation and Discomfort with **Diagnosing Sepsis**: Survey of a Pediatric Tertiary Care Center (Breuer, Ryan K.; Hassinger, Amanda B) • "Learn From Every Patient": How a **Learning Health System Can Improve Patient Care** (Noritz, Garey; Boggs, Adam; Lowes, Linda P.; Smoyer, William E.) • Improving **Handoffs Between Operating Room and Pediatric Intensive Care** Teams: Before and After Study (Malenka, Emma C.; Nett, Sholeen T.; Fussell, Melissa; Braga, Matthew S.) • Evaluating Interventions to Increase **Influenza Vaccination** Rates among Pediatric Inpatients (Rao, Suchitra; Fischman, Victoria; Kaplan, David W.; Wilson, Karen M.; Hyman, Daniel) • Decreasing **Blood Culture Contaminants** in a Pediatric Emergency Department: An Interrupted Time Series Analysis (Mullan, Paul C.; Scott, Sara; Chamberlain, James M.; Pettinichi, Jeanne; Palacious, Katura; Weber, Anastasia; Payne, Asha S.; Badolato, Gia M.; Brown, Kathleen) • Using Quality Improvement to Change Testing Practices for **Community-acquired Pneumonia** (Rogers, Amanda J.; Lye, Patricia S.; Ciener, Daisy A.; Ren, Bixiang; Kuhn, Evelyn M.; Morrison, Andrea K.)

	• Reduction of **Analgesia Duration** after Tracheostomy during Neonatal Intensive Care: A Quality Initiative (Puthoff, Teresa D.; Shah, Hevil; Slaughter, Jonathan L.; Bapat, Roopali) • Decreasing **Unexpected Returns to Orthopedic Hand Clinic**: Improving Efficiency of Health Care Delivery (Little, Kevin J.; Trehan, Samir; Cornwall, Roger; Garrison, Stephanie; Dastillung, Emily; McFadden, Lisa) • Automated E-mail Reminders Linked to Electronic Health Records to Improve **Medication Reconciliation on Admission** (Johnson, Kristen; Burkett, Gregory S.; Nelson, Daniel; Chen, Allen R.; Matlin, Carol; Garger, Cathy; McMahan, Steven; Hughes, Helen; Miller, Marlene; Kim, Julia M.) • **Adherence to Daily Weights and Total Fluid Orders** in the Pediatric Intensive Care Unit (Ahearn, Marshall A.; Soranno, Danielle E.; Stidham, Timothy; Lusk, Jennifer; Gist, Katja M.) • Decreasing Unplanned Office Visits Due to **Cast Problems in the Pediatric Population** (Newman, Sharon Lee; Gaffney, John T.) • Dissemination of a Novel Framework to Improve **Blood Culture Use** in Pediatric Critical Care (Woods-Hill, Charlotte Z.; Lee, Laura; Xie, Anping; King, Anne F.; Voskertchian, Annie; Klaus, Sybil A.; Smith, Michelle M.; Miller, Marlene R.; Colantuoni, Elizabeth A.; Fackler, J. C.; Milstone, A. M.) • **Surgical Safety Checklists in Children's Surgery**: Surgeons' Attitudes and Review of the Literature (Roybal, Jessica; Tsao, KuoJen; Rangel, Shawn; Ottosen, Madelene; Skarda, David; Berman, Loren; For the American Pediatric Surgical Association Quality and Safety Committee) • Association between Practice Participation in a **Pediatric-focused Medical Home Learning Collaborative and Reduction of Preventable Emergency Department Visits** by Publicly-insured Children in Massachusetts (Kirby, Paul B.; Christensen, Anna L.; Bannister, Louise; Konar, Valerie) • The **Aggregate Point Rule** for Identifying Shifts on **P Charts and U Charts** (Wheeler, T. Arthur; Davis, J. Terrance; Brilli, Richard J.)

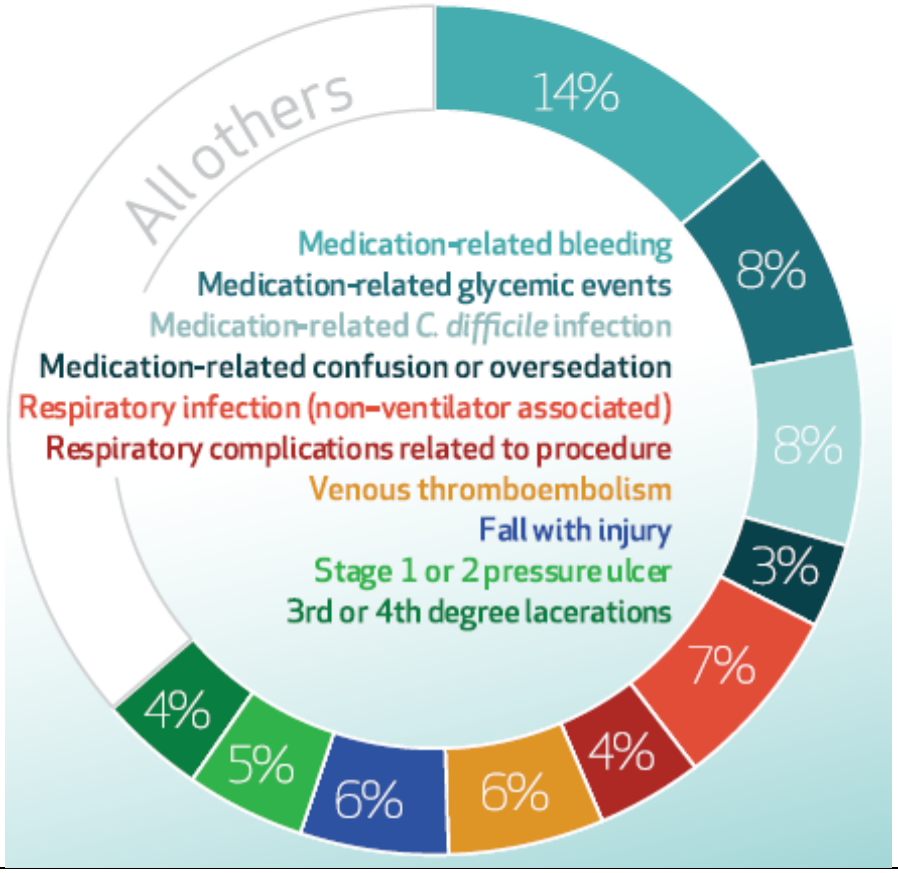
Health Affairs
Volume: 37, Number: 11 (November 2018)

URL	https://www.healthaffairs.org/toc/hlthaff/37/10
Notes	A new issue of *Health Affairs* has been published, with the theme of '**Patient Safety**'. Articles in this issue include: • In **Patient Safety** Efforts, **Pharmacists** Gain New Prominence (R Gale) • A **Medical School For The Community** (Jessica Bylander) • Two Decades Since *To Err Is Human*: An Assessment Of **Progress And Emerging Priorities In Patient Safety** (David W Bates, and Hardeep Singh) • Nurses' And Patients' Appraisals Show **Patient Safety In Hospitals Remains A Concern** (Linda H Aiken, Douglas M Sloane, Hilary Barnes, Jeannie P Cimiotti, Olga F Jarrín, and Matthew D McHugh) • Identifying **Electronic Health Record Usability And Safety Challenges** In Pediatric Settings (Raj M Ratwani, Erica Savage, Amy Will, Allan Fong, Dean Karavite, Naveen Muthu, A Joy Rivera, Cori Gibson, Don Asmonga, Ben Moscovitch, Robert Grundmeier, and Josh Rising) • **Accurate Measurement** In California's Safety-Net Health Systems Has Gaps And Barriers (Elaine C Khoong, Roy Cherian, Natalie A Rivadeneira, Gato Gourley, Jinoos Yazdany, Ashrith Amarnath, Dean Schillinger, and U Sarkar)

	• Does Nursing Home Compare Reflect **Patient Safety In Nursing Homes**? (Daniel Brauner, Rachel M Werner, Tetyana P Shippee, John Cursio, Hari Sharma, and R Tamara Konetzka) • Scaling Safety: The South Carolina **Surgical Safety Checklist** Experience (William R Berry, Lizabeth Edmondson, Lorri R Gibbons, Ashley Kay Childers, Alex B Haynes, Richard Foster, Sara J Singer, and Atul A Gawande) • Success In **Hospital-Acquired Pressure Ulcer Prevention**: A Tale In Two Data Sets (Shawna Smith, Ashley Snyder, Laurence F McMahonJr., Laura Petersen, and Jennifer Meddings) • Enhancing **Safety Culture** Through Improved **Incident Reporting**: A Case Study In Translational Research (Kelsey Flott, Darren Nelson, Tammy Moorcroft, Erik K Mayer, William Gage, Julian Redhead, and Ara W Darzi) • An **Electronic Health Record–Based Real-Time Analytics Program For Patient Safety Surveillance** And Improvement (David Classen, Michael Li, Suzanne Miller, and Drew Ladner) • **Patient Engagement In Health Care Safety**: An Overview Of Mixed-Quality Evidence (Anjana E Sharma, Natalie A Rivadeneira, Jill Barr-Walker, Rachel J Stern, Amanda K Johnson, and Urmimala Sarkar) • Learning From Patients' Experiences Related To **Diagnostic Errors** Is Essential For Progress In Patient Safety (Traber Davis Giardina, Helen Haskell, Shailaja Menon, Julia Hallisy, Frederick S Southwick, Urmimala Sarkar, Kathryn E Royse, and Hardeep Singh) • Payment Innovations To Improve **Diagnostic Accuracy** And Reduce Diagnostic Error (Robert Berenson, and Hardeep Singh) • Effects Of A **Communication-And-Resolution Program** On Hospitals' Malpractice Claims And Costs (Allen Kachalia, Kenneth Sands, Melinda Van Niel, Suzanne Dodson, Stephanie Roche, Victor Novack, Maayan Yitshak-Sade, Patricia Folcarelli, Evan M. Benjamin, A C Woodward, and M M Mello) • Can **Communication-And-Resolution Programs** Achieve Their Potential? Five Key Questions (Thomas H Gallagher, Michelle M Mello, William M Sage, Sigall K Bell, Timothy B McDonald, and Eric J Thomas) • **Patient Safety In Inpatient Psychiatry**: A Remaining Frontier For Health Policy (Morgan C Shields, Maureen T Stewart, and Kathleen R Delaney) • Challenges And Opportunities For **Improving Patient Safety Through Human Factors And Systems Engineering** (Pascale Carayon, Abigail Wooldridge, Bat-Zion Hose, Megan Salwei, and James Benneyan) • Interpersonal And Organizational Dynamics Are Key Drivers Of **Failure To Rescue** (Margaret E Smith, Emily E Wells, Christopher R Friese, Sarah L Krein, and Amir A Ghaferi) • A Prescription For Enhancing **Electronic Prescribing Safety** (Gordon Schiff, Maria M Mirica, Ajit A Dhavle, William L Galanter, Bruce Lambert, and Adam Wright) • The **Architecture Of Safety**: An Emerging Priority For Improving Patient Safety (Anjali Joseph, Kerm Henriksen, and Eileen Malone) • Reversing The Rise In **Maternal Mortality** (Katy B. Kozhimannil)

SAFETY IN THE HOSPITAL

Of the nearly 4,000 adverse events at two geographically distinct large US hospitals during 2014–17, the most prevalent were medication- and respiratory-related issues, as well as injuries. The Safe Surgery South Carolina Program implemented a surgical checklist that lowered postoperative surgical mortality by 22% in 2013, and achieving those outcomes required active involvement from the top down and a range of activity types. Finally, at three pediatric and mixed pediatric/adult hospitals during 2012–17, 19% of safety reports related to usability issues with electronic health records (EHRs) may have resulted in patient harm.



BMJ Quality and Safety online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	*BMJ Quality and Safety* has published a number of 'online first' articles, including: • Effects and costs of implementing **predictive risk stratification in primary care**: a randomised stepped wedge trial (Helen Snooks, Kerry Bailey-Jones, Deborah Burge-Jones, Jeremy Dale, Jan Davies, Bridie Angela Evans, Angela Farr, Deborah Fitzsimmons, Martin Heaven, Helen Howson, Hayley Hutchings, Gareth John, Mark Kingston, Leo Lewis, Ceri Phillips, Alison Porter, Bernadette Sewell, Daniel Warm, Alan Watkins, Shirley Whitman, Victoria Williams, Ian Russell)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • A nation-wide transition in **patient safety culture**: a multilevel analysis on two cross-sectional surveys (I Verbeek-van Noord; M Smits; N C Zwijnenberg; P Spreeuwenberg; C Wagner) • Increasing **early surgery** within 2 days for **hip fracture**: a time trend in 15 EU countries (2000–13) (Maria Michela Gianino; Jacopo Lenzi; Marco Bonaudo; MariaPia Fantini; Roberta Siliquini; Walter Ricciardi; Gianfranco Damiani) • **Second victims in the labor ward**: Are Danish midwives and obstetricians getting the support they need? (Katja Schrøder; Hanan H Edrees; René dePont Christensen; Jan Stener Jørgensen; Ronald Frances Lamont; Niels C Hvid) • Support for teams, technology and **patient involvement in decision-making** associated with support for patient-centred care (Amédé Gogovor; Marie-France Valois; Gillian Bartlett; Sara Ahmed) • **E-learning on risk management**. An opportunity for sharing knowledge and experiences in patient safety (Yolanda Agra; Víctor García-Álvarez; Carlos Aibar-Remón; Jesús Aranaz; Yuri Villán; Miguel Recio) • Shades of competence? A critical analysis of the **cultural competencies** of the regulated-health workforce in Aotearoa New Zealand (Deborah Heke; Denise Wilson; Heather Came)

Online resources

[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk
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 NG88 ***Heavy menstrual bleeding**: assessment and management*
  https://www.nice.org.uk/guidance/ng88

[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:

- ***Stroke Prevention** in Patients With **Atrial Fibrillation**: A Systematic Review Update*
  https://effectivehealthcare.ahrq.gov/topics/stroke-afib-update/research-2018

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