



## On the Radar

Issue 360

5 March 2018

*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.

*On the Radar* is available online, via email or as a PDF or Word document from <https://www.safetyandquality.gov.au/publications-resources/on-the-radar/>

If you would like to receive *On the Radar* via email, you can subscribe on our website <https://www.safetyandquality.gov.au/> or by emailing us at [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au). You can also send feedback and comments to [mail@safetyandquality.gov.au](mailto:mail@safetyandquality.gov.au).

For information about the Commission and its programs and publications, please visit <https://www.safetyandquality.gov.au>  
You can also follow us on Twitter @ACSQHC.

---

### On the Radar

Editor: Dr Niall Johnson [niall.johnson@safetyandquality.gov.au](mailto:niall.johnson@safetyandquality.gov.au)

Contributors: Niall Johnson, Kim Stewart

### Reports

*Australian Group on Antimicrobial Resistance. Sepsis Outcome Programs 2016 Report*

Coombs G, Bell JM, Daley D, Collignon P, Cooley L, Gottlieb T, Iredell J, Kotsanas D, Nimmo G and Robson J on behalf of the Australian Group on Antimicrobial Resistance, Turnidge JD.  
Sydney: ACSQHC; 2018.p.99.

*CARAlert Summary Report 1 April 2017–30 September 2017*

Australian Commission on Safety and Quality in Health Care  
Sydney: ACSQHC; 2018. p. 30.

URL	AGAR report <a href="https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/AGAR-Sepsis-Outcome-Program-2016-Report-February-2018.pdf">https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/AGAR-Sepsis-Outcome-Program-2016-Report-February-2018.pdf</a> CARAlert <a href="https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/CARAlert-Summary-Report-1-Apr-2017-to-30-Sep-2017.pdf">https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/CARAlert-Summary-Report-1-Apr-2017-to-30-Sep-2017.pdf</a>
Notes	The Australian Commission on Safety and Quality in Health Care recently released two new AURA Surveillance System reports - the <i>Australian Group on Antimicrobial Resistance. Sepsis Outcome Programs 2016 Report</i> (the AGAR report) and the <i>CARAlert Summary Report 1 April 2017–30 September 2017</i> (the CARAlert report).

	<p>The AGAR report included analyses of data reported by 32 participating public and private laboratories on blood stream infections in Australian hospital and community settings. The CARAlert report included analyses of data reported from April to September 2017 by 65 public and private laboratories on confirmed critical antimicrobial resistances to last-line antibiotics.</p> <p>The AGAR report confirmed that vancomycin-resistant enterococci are becoming a major healthcare problem in Australia, including that approximately 75% of <i>Staphylococcus aureus</i> bacteraemia episodes originated in the community rather than in hospitals, and identified concerning increasing fluoroquinolone resistance in invasive <i>Escherichia coli</i>.</p> <p>The CARAlert report highlights increasing rates of azithromycin non-susceptible <i>Neisseria gonorrhoeae</i> that have implications for sexually transmitted infection prevention and treatment programs, as well as the relatively low, but nevertheless concerning, rate of carbapenemase-producing Enterobacteriaceae.</p> <p>The AGAR and CARAlert analyses affirm the importance of using the NSQHS Standard Preventing and Controlling Healthcare-Associated Infection to ensure health services have systems and strategies in place to prevent and manage infection. These strategies include strict adherence to infection control guidelines, effective cleaning and sterilisation in healthcare facilities and implementation of the Commission’s 2017 <i>Recommendations for the control of carbapenemase-producing Enterobacteriaceae: A guide for acute health facilities</i>. These recommendations are available at <a href="https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/cpe-guide/">https://www.safetyandquality.gov.au/our-work/healthcare-associated-infection/cpe-guide/</a></p>
--	--

*Oakden: A Shameful Chapter in South Australia’s History*

A report by the Hon Bruce Lander QC Independent Commissioner Against Corruption

Lander B

Adelaide: Independent Commission Against Corruption; 2018. p. 456.

URL	<a href="https://icac.sa.gov.au/sites/default/files/ICAC_Report_Oakden.pdf">https://icac.sa.gov.au/sites/default/files/ICAC_Report_Oakden.pdf</a>
Notes	<p>The South Australian Independent Commissioner Against Corruption, the Hon. Bruce Lander QC, has published his investigation report in relation to the Oakden Older Persons Mental Health Facility. The report made findings against five individuals and the Northern Adelaide Local Health Network. It also makes 13 recommendations covering:</p> <ul style="list-style-type: none"> <li>• reviewing the clinical governance and management of mental health services within the overall clinical governance of each Local Health Network (LHN)</li> <li>• adopting management structures for the administration of the Mental Health Act 2009 (MHA) to match those of overall mental health clinical governance structures</li> <li>• implementing a structure to routinely remind all staff working at a treatment centre of the management structure in place at the centre; the assignment of responsibilities at the centre; and the expectations and responsibilities imposed upon each member of staff at the centre</li> <li>• directing all staff at facilities in a LHN where mental health services are being delivered to undergo training in the use of the Safety Learning System; the reporting obligations for staff and the relevant policies and procedures</li> <li>• Chief Psychiatrist conducting unannounced visits to facilities more frequently than in the past</li> <li>• Principal Community Visitor conducting unannounced inspections and visits of facilities more frequently than in the past</li> <li>• Conducting a review of the community visitor scheme (CVS)</li> </ul>

	<ul style="list-style-type: none"> <li>• Conducting a review to determine whether the MHA should be amended to impose positive obligations on the Chief Psychiatrist and whether the powers, function and resources of the Chief Psychiatrist need to be increased</li> <li>• Conducting a review reporting publicly on the physical condition of all facilities at which mental health services are delivered</li> <li>• Reviewing the role of Consumer Advisor, including duties and responsibilities, training and independence</li> <li>• Reviewing the use of restrictive practices within each LHN and consider issuing new standards in relation to the use of restrictive practices</li> <li>• Reviewing the level and nature of allied health staff support at facilities at which mental health services are provided.</li> </ul>
--	---

*Prevalence and economic burden of medication errors in the NHS in England:*

Rapid evidence synthesis and economic analysis of the prevalence and burden of medication error in the UK

Elliott RA, Camacho E, Campbell F, Jankovic D, Martyn St James M, Kaltenthaler E, et al. Sheffield and York: Policy Research Unit in Economic Evaluation of Health and Care Interventions. Universities of Sheffield and York.; 2018.

*The Report of the Short Life Working Group on reducing medication-related harm*

Short Life Working Group on reducing medication-related harm

London: Department of Health and Social Care; 2018. p. 24.

DOI	Elliott et al <a href="http://www.cepru.org.uk/prevalence-and-economic-burden-of-medication-errors-in-the-nhs-in-england-2/">http://www.cepru.org.uk/prevalence-and-economic-burden-of-medication-errors-in-the-nhs-in-england-2/</a> <a href="https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report">https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report</a>
Notes	<p>A pair of reports from the UK on medication error and the harms that can arise. Elliott et al provide a new British study that reminds us of the scale of the medication errors issue. The authors of this report reviewed 36 studies and “estimated that <b>237 million medication errors</b> occur at some point in the medication process in England per year. This is a large number, but 72% have little/no potential for harm.” They “estimated that <b>66 million potentially clinically significant errors occur per year, 71.0% of these in primary care.</b> This is where most medicines in the NHS are prescribed and dispensed. Prescribing in primary care accounts for 33.9% of all potentially clinically significant errors.” Estimates of the NHS costs of definitely avoidable adverse drug reactions (ADRs) are at least “<b>£98.5 million per year, consuming 181,626 bed-days, causing 712 deaths, and contributing to 1,708 deaths</b>”.</p> <p>They observe that “<b>Non-steroidal anti-inflammatory drugs, anticoagulants and antiplatelets</b> cause over a third of admissions due to avoidable ADRs” while “<b>Gastrointestinal (GI) bleeds</b> are implicated in half of the deaths from primary care ADRs. <b>Older people are more likely to suffer</b> avoidable ADRs.”</p> <p>The UK Department of Health and Social Care had commissioned the Elliot et al report. The department also established a Short Life Working Group on reducing medication-related harm. The Group has produced this report that provides recommendations for a programme of work to tackle medication error and improve medicine safety. It highlights the use of technology and cultural change as key to improving medication safety and the prevention of avoidable harm.</p>

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

## Journal articles

*Journal of Antimicrobial Chemotherapy*

Volume 73, Issue suppl\_2

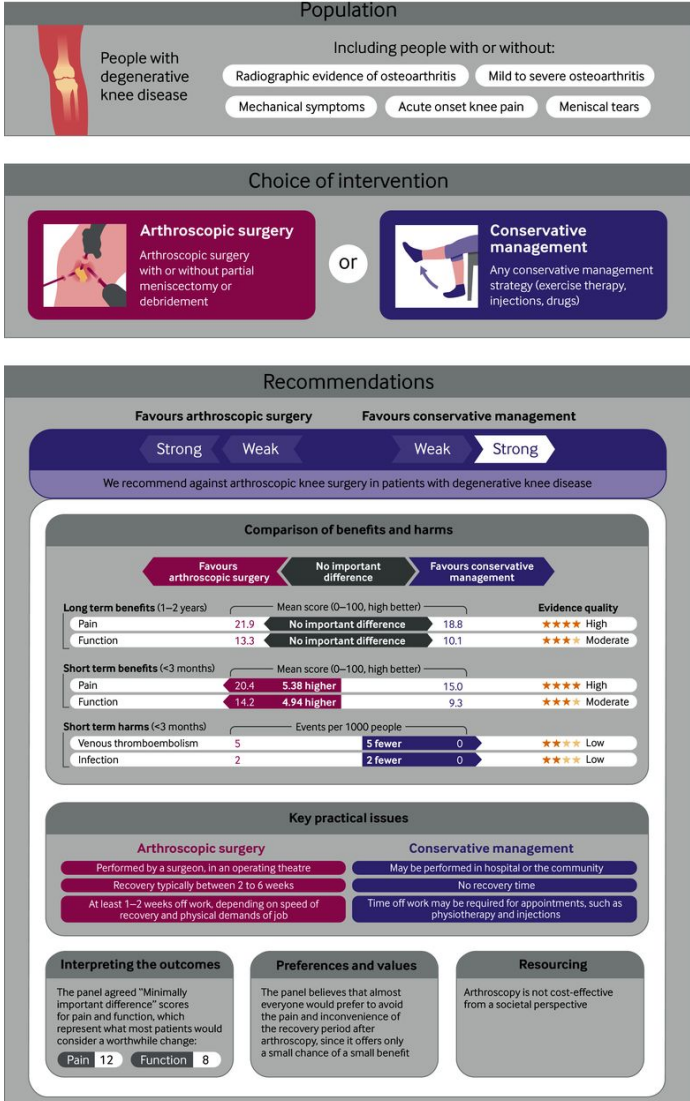
February 2018

URL	Supplement <a href="https://academic.oup.com/jac/issue/73/suppl_2">https://academic.oup.com/jac/issue/73/suppl_2</a>
Notes	<p>This supplement to the <i>Journal of Antimicrobial Chemotherapy</i> bears the theme ‘<b>Appropriateness of antibiotic prescribing in English primary care</b>’ and examines the issues of the overprescribing of antibiotics, and the associated dangers. The papers in the Supplement are:</p> <ul style="list-style-type: none"> <li>• Antibiotics in primary care in England: <b>which antibiotics are prescribed</b> and for which conditions? (F Christiaan K Dolk; Koen B Pouwels; David R M Smith; Julie V Robotham; Timo Smieszek)</li> <li>• <b>Defining the appropriateness and inappropriateness of antibiotic prescribing</b> in primary care (David R M Smith; F Christiaan K Dolk; Koen B Pouwels; Morag Christie; Julie V Robotham; Timo Smieszek)</li> <li>• <b>Actual versus ‘ideal’ antibiotic prescribing</b> for common conditions in English primary care (Koen B Pouwels; F Christiaan K Dolk; David R M Smith; Julie V Robotham; Timo Smieszek)</li> <li>• Explaining <b>variation in antibiotic prescribing</b> between general practices in the UK (Koen B Pouwels; F Christiaan K Dolk; David R M Smith; Timo Smieszek; Julie V Robotham)</li> <li>• Potential for <b>reducing inappropriate antibiotic prescribing</b> in English primary care (Timo Smieszek; Koen B Pouwels; F Christiaan K Dolk; David R M Smith; Susan Hopkins; Mike Sharland; Alastair D Hay; Michael V Moore; Julie V Robotham)</li> </ul> <p>According to a release from Public Health England, (available at <a href="https://www.gov.uk/government/news/research-reveals-levels-of-inappropriate-prescriptions-in-england">https://www.gov.uk/government/news/research-reveals-levels-of-inappropriate-prescriptions-in-england</a>), “At least <b>20% of all antibiotics prescribed in primary care in England are inappropriate</b>” and continues:</p> <p>The research found that the <b>majority of antibiotic prescriptions</b> in English primary care were for <b>infections of the respiratory and urinary tracts</b>. However, in almost <b>a third of all prescriptions, no clinical reason</b> was documented. Antibiotic prescribing rates varied substantially between GP practices, nonetheless, there is scope for all practices across the country to reduce their rates of prescribing.</p> <p>For most conditions, substantially higher proportions of GP consultations resulted in an antibiotic prescription than is appropriate according to expert opinion. An antibiotic was prescribed in 41% of all uncomplicated acute cough consultations when experts advocated 10%, as well as:</p> <ul style="list-style-type: none"> <li>• bronchitis (actual: 82% versus ideal: 13%)</li> <li>• sore throat (actual: 59% versus ideal: 13%)</li> <li>• rhinosinusitis (actual: 88% versus ideal: 11%)</li> <li>• acute otitis media in 2 to 18 year olds (actual: 92% versus ideal: 17%)</li> </ul> <p>This work demonstrates the existence of <b>substantial inappropriate antibiotic prescribing</b> and poor diagnostic coding in English primary care. Better diagnostic coding, more precise prescribing guidelines, and a deeper understanding of appropriate long-term uses of antibiotics would allow identification of further reduction potentials.</p>

For information about the Commission’s work on antimicrobial use and resistance in Australia, see <https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/>

*Arthroscopic surgery for degenerative knee arthritis and meniscal tears: a clinical practice guideline*

Siemieniuk RAC, Harris IA, Agoritsas T, Poolman RW, Brignardello-Petersen R, Van de Velde S, et al British Journal of Sports Medicine. 2018;52(5):313-.

DOI	<p><a href="http://dx.doi.org/10.1136/bjsports-2017-j1982rep">http://dx.doi.org/10.1136/bjsports-2017-j1982rep</a></p> <p>An expert panel produced these recommendations based on a linked systematic review triggered by a randomised trial published in <i>The BMJ</i> in June 2016, which found that, among patients with a degenerative medial meniscus tear, knee arthroscopy was no better than exercise therapy. The panel make a strong recommendation against arthroscopy for degenerative knee disease. The panel wrote:</p> <ul style="list-style-type: none"> <li>• We make a strong recommendation against the use of arthroscopy in nearly all patients with degenerative knee disease, based on linked systematic reviews; further research is unlikely to alter this recommendation</li> <li>• This recommendation applies to patients with or without imaging evidence of osteoarthritis, mechanical symptoms, or sudden symptom onset</li> <li>• Healthcare administrators and funders may use the number of arthroscopies performed in patients with degenerative knee disease as an indicator of quality care.</li> </ul>  <p><b>Population</b></p> <p>People with degenerative knee disease</p> <p>Including people with or without:</p> <ul style="list-style-type: none"> <li>Radiographic evidence of osteoarthritis</li> <li>Mild to severe osteoarthritis</li> <li>Mechanical symptoms</li> <li>Acute onset knee pain</li> <li>Meniscal tears</li> </ul> <p><b>Choice of intervention</b></p> <p><b>Arthroscopic surgery</b> Arthroscopic surgery with or without partial meniscectomy or debridement</p> <p>OR</p> <p><b>Conservative management</b> Any conservative management strategy (exercise therapy, injections, drugs)</p> <p><b>Recommendations</b></p> <p>Favours arthroscopic surgery      Favours conservative management</p> <p>Strong   Weak   Weak   Strong</p> <p>We recommend against arthroscopic knee surgery in patients with degenerative knee disease</p> <p><b>Comparison of benefits and harms</b></p> <table border="1"> <thead> <tr> <th></th> <th>Favours arthroscopic surgery</th> <th>No important difference</th> <th>Favours conservative management</th> <th>Evidence quality</th> </tr> </thead> <tbody> <tr> <td colspan="5"><b>Long term benefits (1–2 years)</b> Mean score (0–100, high better)</td> </tr> <tr> <td>Pain</td> <td>21.9</td> <td>No important difference</td> <td>18.8</td> <td>★★★★ High</td> </tr> <tr> <td>Function</td> <td>13.3</td> <td>No important difference</td> <td>10.1</td> <td>★★★★ Moderate</td> </tr> <tr> <td colspan="5"><b>Short term benefits (&lt;3 months)</b> Mean score (0–100, high better)</td> </tr> <tr> <td>Pain</td> <td>20.4</td> <td>5.38 higher</td> <td>15.0</td> <td>★★★★ High</td> </tr> <tr> <td>Function</td> <td>14.2</td> <td>4.94 higher</td> <td>9.3</td> <td>★★★★ Moderate</td> </tr> <tr> <td colspan="5"><b>Short term harms (&lt;3 months)</b> Events per 1000 people</td> </tr> <tr> <td>Venous thromboembolism</td> <td>5</td> <td>5 fewer</td> <td>0</td> <td>★★★★ Low</td> </tr> <tr> <td>Infection</td> <td>2</td> <td>2 fewer</td> <td>0</td> <td>★★★★ Low</td> </tr> </tbody> </table> <p><b>Key practical issues</b></p> <table border="1"> <thead> <tr> <th>Arthroscopic surgery</th> <th>Conservative management</th> </tr> </thead> <tbody> <tr> <td>Performed by a surgeon, in an operating theatre</td> <td>May be performed in hospital or the community</td> </tr> <tr> <td>Recovery typically between 2 to 6 weeks</td> <td>No recovery time</td> </tr> <tr> <td>At least 1–2 weeks off work, depending on speed of recovery and physical demands of job</td> <td>Time off work may be required for appointments, such as physiotherapy and injections</td> </tr> </tbody> </table> <p><b>Interpreting the outcomes</b> The panel agreed “Minimally important difference” scores for pain and function, which represent what most patients would consider a worthwhile change. Pain 12    Function 8</p> <p><b>Preferences and values</b> The panel believes that almost everyone would prefer to avoid the pain and inconvenience of the recovery period after arthroscopy, since it offers only a small chance of a small benefit.</p> <p><b>Resourcing</b> Arthroscopy is not cost-effective from a societal perspective.</p>		Favours arthroscopic surgery	No important difference	Favours conservative management	Evidence quality	<b>Long term benefits (1–2 years)</b> Mean score (0–100, high better)					Pain	21.9	No important difference	18.8	★★★★ High	Function	13.3	No important difference	10.1	★★★★ Moderate	<b>Short term benefits (&lt;3 months)</b> Mean score (0–100, high better)					Pain	20.4	5.38 higher	15.0	★★★★ High	Function	14.2	4.94 higher	9.3	★★★★ Moderate	<b>Short term harms (&lt;3 months)</b> Events per 1000 people					Venous thromboembolism	5	5 fewer	0	★★★★ Low	Infection	2	2 fewer	0	★★★★ Low	Arthroscopic surgery	Conservative management	Performed by a surgeon, in an operating theatre	May be performed in hospital or the community	Recovery typically between 2 to 6 weeks	No recovery time	At least 1–2 weeks off work, depending on speed of recovery and physical demands of job	Time off work may be required for appointments, such as physiotherapy and injections
	Favours arthroscopic surgery	No important difference	Favours conservative management	Evidence quality																																																							
<b>Long term benefits (1–2 years)</b> Mean score (0–100, high better)																																																											
Pain	21.9	No important difference	18.8	★★★★ High																																																							
Function	13.3	No important difference	10.1	★★★★ Moderate																																																							
<b>Short term benefits (&lt;3 months)</b> Mean score (0–100, high better)																																																											
Pain	20.4	5.38 higher	15.0	★★★★ High																																																							
Function	14.2	4.94 higher	9.3	★★★★ Moderate																																																							
<b>Short term harms (&lt;3 months)</b> Events per 1000 people																																																											
Venous thromboembolism	5	5 fewer	0	★★★★ Low																																																							
Infection	2	2 fewer	0	★★★★ Low																																																							
Arthroscopic surgery	Conservative management																																																										
Performed by a surgeon, in an operating theatre	May be performed in hospital or the community																																																										
Recovery typically between 2 to 6 weeks	No recovery time																																																										
At least 1–2 weeks off work, depending on speed of recovery and physical demands of job	Time off work may be required for appointments, such as physiotherapy and injections																																																										

Notes



	<p>The first <i>Australian Atlas of Healthcare Variation</i> examined knee arthroscopy admissions for people aged 55 and over, while <i>The Second Australian Atlas of Healthcare Variation</i> included an examination of knee replacement hospitalisations. The atlases, interactive atlases and data are all available. For more information, see <a href="https://www.safetyandquality.gov.au/atlas">https://www.safetyandquality.gov.au/atlas</a></p> <p>This was followed by the <i>Osteoarthritis of the Knee Clinical Care Standard</i>. The standard, along with supporting materials, including the indicator specification, fact sheets for clinicians and consumers, evidence base and infographics are available at <a href="https://www.safetyandquality.gov.au/our-work/clinical-care-standards/osteoarthritis-clinical-care-standard/">https://www.safetyandquality.gov.au/our-work/clinical-care-standards/osteoarthritis-clinical-care-standard/</a></p>
--	--

*BMJ Quality and Safety* online first articles

URL	<a href="https://qualitysafety.bmj.com/content/early/recent">https://qualitysafety.bmj.com/content/early/recent</a>
Notes	<p><i>BMJ Quality and Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> <li>• <b>Patient participation in inpatient ward rounds</b> on acute inpatient medical wards: a descriptive study (Bernice Redley, Lauren McTier, Mari Botti, Alison Hutchinson, Harvey Newnham, Donald Campbell, Tracey Bucknall)</li> <li>• Ethical <b>decision-making climate in the ICU</b>: theoretical framework and validation of a self-assessment tool (Bo Van den Bulcke, Ruth Piers, Hanne Irene Jensen, Johan Malmgren, Victoria Metaxa, Anna K Reyners, Michael Darmon, Katerina Rusinova, Daniel Talmor, Anne-Pascale Meert, Laura Cancelliere, László Zubek, Paolo Maia, Andrej Michalsen, Johan Decruyenaere, Erwin J O Kompanje, Elie Azoulay, Reitske Meganck, Ariëlla Van de Sompel, Stijn Vansteelandt, Peter Vlerick, Stijn Vanheule, Dominique D Benoit)</li> </ul>

*International Journal for Quality in Health Care* online first articles

URL	<a href="https://academic.oup.com/intqhc/advance-access?papetoc">https://academic.oup.com/intqhc/advance-access?papetoc</a>
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"> <li>• ‘<b>Choosing Wisely</b>’ culture among <b>Brazilian cardiologists</b> (Luis C L Correia; Guilherme B Barcellos; Vitor Calixto; André Volschan; José A S Barreto-Filho; Renato D Lopes; Anis Rassi, Jr; Wendy Levinson; Angelo A V de Paola)</li> <li>• <b>Quality of care and variability in lung cancer management</b> across Belgian hospitals: a population-based study using routinely available data (France Vrijens; Cindy De Gendt; Leen Verleye; Jo Robays; Viki Schillemans; Cécile Camberlin; Sabine Stordeur; Cécile Dubois; Elisabeth Van Eycken; Isabelle Wauters; Jan P Van Meerbeeck)</li> <li>• <b>Hospitalization from the patient perspective</b>: a data linkage study of adults in Australia (Reema Harrison; Merylyn Walton; Patrick Kelly; Elizabeth Manias; Christine Jorm; Jennifer Smith-Merry; Rick Iedema; Karen Luxford; Amalie Dyda)</li> </ul>

## Online resources

[UK] National Institute for Health Research

<https://discover.dc.nihr.ac.uk/portal/search/signals>

The UK's National Institute for Health Research (NIHR) Dissemination Centre has released the latest 'Signals' research summaries. This latest release includes:

- Diet and exercise programmes can **prevent diabetes** in high-risk individuals
- Inhaled **anaesthesia** with anti-sickness medication in children has the same risk of **vomiting** as intravenous anaesthesia
- Calcium channel blockers are useful in managing **Raynaud's phenomenon**
- Additional therapy helps social recovery from **first episode psychosis**
- Free entry for leisure centres may increase **physical activity** across all social groups
- Gout medication may slow progression of **chronic kidney disease**
- Introducing a **primary care risk prediction tool** did not reduce emergency admissions
- A **frailty checklist** was completed in only a quarter of older people at hospital admission
- Diabetes drug aids fertility in women with **polycystic ovaries**
- Rivaroxaban plus aspirin may reduce heart attack and strokes in people with **peripheral arterial disease**, but with an added risk of bleeding.

---

### Disclaimer

*On the Radar* is an information resource of the Australian Commission on Safety and Quality in Health Care. The Commission is not responsible for the content of, nor does it endorse, any articles or sites listed. The Commission accepts no liability for the information or advice provided by these external links. Links are provided on the basis that users make their own decisions about the accuracy, currency and reliability of the information contained therein. Any opinions expressed are not necessarily those of the Australian Commission on Safety and Quality in Health Care.