



On the Radar

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On the Radar

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***Australian Atlas of Healthcare Variation Time Series Reports (2016–17 to 2020–21):
Opioid Medicines Dispensing, all ages and
Antipsychotic Medicines Dispensing, 65 years and over.***

Australian Commission on Safety and Quality in Healthcare
Sydney: ACSQHC; 2022

<https://www.safetyandquality.gov.au/our-work/healthcare-variation/australian-atlas-healthcare-variation-series>

The Australian Commission on Safety and Quality in Healthcare has released two new Atlas Time Series Reports that show trend data from 2016–17 to 2020–21 on opioid medicines dispensing, all ages, and antipsychotic medicines dispensing, 65 years and over.

The reports, which build on data from the [*Third Australian Atlas of Healthcare Variation*](#), reveal a decline in dispensing of the high-risk medicines over five years but continuing variation across the country.

Dispensing rates fell nationally and in all states and territories. In the five years to 2020–21, there was an 18% reduction nationally in opioids dispensing rates and an 11% reduction in antipsychotics dispensing. However, the reports indicate continuing variation and potential misuse of opioids and antipsychotics in some geographical areas with consistently high dispensing rates.

Using PBS data*, the reports examine opioid and antipsychotic medicines dispensing across Australia at national, state and territory, Primary Health Network (PHN) and local levels.

Health services, PHNs, general practitioners and other clinicians can use data from the interactive reports to review rates of medicines dispensing in their local area and compare with rates for similar areas.

The reports will help identify areas that may benefit from further investigation and targeted strategies to improve appropriate prescribing of these high-risk medicines.

For more information email atlas@safetyandquality.gov.au

* Pharmaceutical Benefits Scheme (PBS) data cover medicines dispensed in the community and in residential aged care. It does not cover medicines supplied in hospital or private prescriptions.

Reports

Medicine safety: disability care. Safer medicines use in people with disability

Lim R, Semple S, Kalisch Ellett LM, Roughead E.

Canberra: Pharmaceutical Society of Australia; 2002. p. 33.

<p>URL</p>	<p>https://www.psa.org.au/advocacy/working-for-our-profession/medicine-safety/disability-care/</p>
<p>Notes</p>	<p>This report was prepared for the Pharmaceutical Society of Australia (PSA) by a group of academics at the Quality Use of Medicines and Pharmacy Research Centre at the University of South Australia. In the foreword to the report, the PSA observes that ‘Approximately 4.4 million Australians live with a disability, many requiring complex medical care.’ The report found that people with disability face challenges at all stages of medicine use, including prescribing, dispensing, administration and adherence, and monitoring. There is also an issue in that many safety problems with medicines are likely unreported. The report describes many of the issues around medicine safety for Australian who live with disability, but also includes recommendations and opportunities for improvement.</p> <p>MEDICINE SAFETY IN PEOPLE WITH DISABILITY</p> <p>Medicine safety problems can occur at any stage of the medicine management cycle.</p> <p>Image: Simplified medicine management cycle.^{36,27}</p>

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

Journal articles

Establishing the worth of deprescribing inappropriate medications: are we there yet?

Scott IA, Reeve E, Hilmer SN

Medical Journal of Australia. 2022;217(6):283-286.

DOI	https://doi.org/10.5694/mja2.51686
Notes	This Perspectives piece in the <i>MJA</i> opens with the somewhat provocative statement ‘Ceasing unnecessary medications is a worthy act, but impacts on clinical outcomes are proving elusive’. However, the authors recognise that ‘Medicines that are ineffective or no longer indicated, discordant with care goals or where harms outweigh benefits should be deprescribed.’ The piece goes on to focus rather on clinical trials and offers observations on the approached and conduct of research and clinical trials.

For information on the Commission’s work on medication safety, see

<https://www.safetyandquality.gov.au/our-work/medication-safety>

Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis

Hodkinson A, Zhou A, Johnson J, Geraghty K, Riley R, Zhou A, et al

BMJ. 2022;378:e070442.

DOI	https://doi.org/10.1136/bmj-2022-070442
Notes	The link between burnout and quality and safety has been accepted for some time. This systematic review and meta-analysis sought to ‘the association of physician burnout with the career engagement and the quality of patient care globally’. This project identified 4732 articles, of which 170 observational studies of 239 246 physicians were included in the meta-analysis. The authors concluded that ‘This meta-analysis provides compelling evidence that physician burnout is associated with poor function and sustainability of healthcare organisations primarily by contributing to the career disengagement and turnover of physicians and secondarily by reducing the quality of patient care’

Effect of an Individualized Audit and Feedback Intervention on Rates of Musculoskeletal Diagnostic Imaging Requests by Australian General Practitioners: A Randomized Clinical Trial

O’Connor DA, Glasziou P, Maher CG, McCaffery KJ, Schram D, Maguire B, et al

Journal of the American Medical Association. 2022;328(9):850-860.

DOI	https://doi.org/10.1001/jama.2022.14587
Notes	Paper in <i>JAMA</i> reporting on an Australian study that sought to examine whether an individualized audit and feedback intervention can reduce musculoskeletal diagnostic imaging usage among high-requesting general practitioners. This was a factorial cluster-randomized clinical trial that ‘included 2271 general practices with at least 1 GP who was in the top 20% of referrers for 11 imaging tests (of the lumbosacral or cervical spine, shoulder, hip, knee, and ankle/hind foot) and for at least 4 individual tests between January and December 2018. Only high-requesting GPs within participating practices were included. The trial was conducted between November 2019 and May 2021, with final follow-up on May 8, 2021.’ The intervention saw individualised written audits and feedback on imaging request rates provided to the participants. The authors report ‘Audit and feedback led to a statistically significant reduction in the overall rate of imaging requests per 1000 consultations compared with control over 12 months (adjusted mean, 27.7 [95% CI, 27.5-28.0] vs 30.4 [95% CI, 29.8-30.9], respectively; adjusted mean difference, -2.66 [95% CI, -3.24 to -2.07]; P < .001).’

For information on the Commission’s recently released *Low Back Pain Clinical Care Standard*, see <https://www.safetyandquality.gov.au/standards/clinical-care-standards/low-back-pain-clinical-care-standard>

Measuring the quality of surgical care in Australia

Watson DI, Bright T

Medical Journal of Australia. 2022 2022/09/19;217(6):301-302.

Hospital costs and factors associated with days alive and at home after surgery (DAH₃₀)

Reilly JR, Myles PS, Wong D, Heritier SR, Brown WA, Richards T, et al

Medical Journal of Australia. 2022;217(6):311-317.

DOI	Watson and Bright https://doi.org/10.5694/mja2.51684 Reilly et al https://doi.org/10.5694/mja2.51658
Notes	Watson and Bright, in their editorial in the <i>MJA</i> , note that ‘Surgical procedures account for large proportions of Australian healthcare activity and costs’ and that ‘ensuring that quality outcomes are consistently delivered should be a priority.’ They proceed to argue that ‘To drive performance improvement, better outcome measures are needed, and the quality of surgical care should ideally be determined in a standardised manner to allow comparisons of surgeons, hospitals, and procedures.’ They advocate the use of the measure of the number of days at home alive in the thirty days following surgery or ‘DAH ₃₀ ’ and refer to a paper in the same issue of the journal (Reilly et al). They note that Reilly et al ‘concluded that higher DAH ₃₀ values indeed “reflect shorter hospital stays and fewer serious complications, re-admissions, and deaths.”’

Communication of Diagnostic Uncertainty in Primary Care and Its Impact on Patient Experience: an Integrative Systematic Review

Dahm MR, Cattanach W, Williams M, Basseal JM, Gleason K, Crock C

Journal of General Internal Medicine. 2022 [epub].

DOI	https://doi.org/10.1007/s11606-022-07768-y
Notes	<p>Uncertainty can be challenging for both patients and clinicians. This paper reports on an integrative systematic literature review that sought to ‘investigate how primary care doctors communicate diagnostic uncertainty in interactions with patients and how patients experience their care in the face of uncertainty’. Focusing on 19 studies, the authors report that:</p> <ul style="list-style-type: none"> • ‘Doctors used two main communication strategies to manage diagnostic uncertainty: (1) patient-centred communication strategies (e.g. use of empathy), and (2) diagnostic reasoning strategies (e.g. excluding serious diagnoses). • Linguistically, diagnostic uncertainty was either disclosed explicitly or implicitly through diverse lexical and syntactical constructions, or not communicated (omission). • Patients’ experiences of care in response to the diverse communicative and linguistic strategies were mixed. • Patient-centred approaches were generally regarded positively by patients.’

For information on the Commission’s work on person-centred care, see

<https://www.safetyandquality.gov.au/our-work/partnering-consumers/person-centred-care>

For information on the Commission’s work on communicating for safety, see

<https://www.safetyandquality.gov.au/our-work/communicating-safety>

The Future of Diagnostic Excellence
 Fineberg HV, Song S, Wang T
 JAMA. 2022;328(11):1039-1040.

DOI	https://doi.org/10.1001/jama.2022.12205
Notes	<p>The authors note that ‘This Viewpoint culminates the JAMA Viewpoint series on diagnostic excellence that included 20 scholarly and insightful articles published over the past 9 months’ They offer a number of key points for the future of diagnostic excellence</p> <ol style="list-style-type: none"> 1. Many technologic initiatives to improve future diagnostic capabilities are already underway. 2. The future of diagnosis will be marked by massive, continuously acquired data, automated interpretation of data streams and data patterns, and personal reference over time of what constitutes a normal result. 3. Increasingly precise diagnoses will allow clinical comparisons across more nearly alike patients and ultimately provide a unique health profile for each individual. 4. The future of diagnosis will emphasize prediction of future health state rather than identification of current disease. 5. Diagnostic excellence begins and ends with the patient.’

BMJ Quality & Safety
 October 2022 Volume 31 Issue 10

URL	https://qualitysafety.bmj.com/content/31/10
Notes	<p>A new issue of <i>BMJ Quality & 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 & Safety</i> include:</p> <ul style="list-style-type: none"> • Editorial: Channelling the force of audit and feedback: averting the dark side (Eilidh M Duncan, Noah M Ivers, Jeremy M Grimshaw) • Editorial: We don’t talk about communication: why technology alone cannot save clinically deteriorating patients (Milisa Manojlovich, Sarah L Krein) • Editorial: Diagnosing diagnostic errors: it’s time to evolve the patient safety research paradigm (David C Stockwell, Paul Sharek) • Using a dark logic model to explore adverse effects in audit and feedback: a qualitative study of gaming in colonoscopy (Jamie Catlow, Rashmi Bhardwaj-Gosling, Linda Sharp, Matthew David Rutter, Falko F Sniehotta) • Nursing implications of an early warning system implemented to reduce adverse events: a qualitative study (Emilie J Braun, Siddhartha Singh, Annie C Penlesky, Erin A Strong, Jeana M Holt, Kathlyn E Fletcher, Michael E Stadler, Ann B Nattinger, Bradley H Crotty) • A scoping review of real-time automated clinical deterioration alerts and evidence of impacts on hospitalised patient outcomes (Robin Blythe, Rex Parsons, Nicole M White, David Cook, Steven McPhail) • Use of e-triggers to identify diagnostic errors in the paediatric ED (Daniel Lam, Fidelity Dominguez, Jan Leonard, Alexandria Wiersma, Joseph A Grubenhoff) • A better way: training for direct observations in healthcare (Myrte de Alfred, John Del Gaizo, Falisha Kanji, Samuel Lawton, Ashley Caron, Lynne S Nemeth, A V Alekseyenko, Daniel Shouhed, Stephen Savage, Jennifer T Anger, Ken Catchpole, Tara Cohen) • Economic evaluations of audit and feedback interventions: a systematic review (Lynne Moore, Jason Robert Guertin, Pier-Alexandre Tardif, Noah

	Michael Ivers, Jeffrey Hoch, Blanchard Conombo, Jesmin Antony, Henry Thomas Stelfox, Simon Berthelot, Patrick Archambault, Alexis Turgeon, Rohit Gandhi, JM Grimshaw)
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BMJ *Quality & Safety* online first articles

URL	https://qualitysafety.bmj.com/content/early/recent
Notes	<p>BMJ <i>Quality & Safety</i> has published a number of ‘online first’ articles, including:</p> <ul style="list-style-type: none"> • Editorial: Impact of medical education on patient safety: finding the signal through the noise (Jasmine Hwang, Rachel Kelz)

Online resources

[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 include:

- NICE Guideline NG122 **Lung cancer: diagnosis and management**
<https://www.nice.org.uk/guidance/ng122>
- Clinical Guideline CG118 **Colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn’s disease or adenomas** <https://www.nice.org.uk/guidance/cg118>

[USA] Reducing Healthcare Carbon Emissions: A Primer on Measures and Actions for Healthcare Organizations to Mitigate Climate Change

<https://www.ahrq.gov/healthsystemsresearch/decarbonization/index.html>

The USA’s Agency for Healthcare Research and Quality (AHRQ) has worked with the Institute for Healthcare Improvement (IHI) to develop this primer providing guidance on high-priority measures and strategies for healthcare organizations to reduce their carbon footprint.

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>

These resources include:

- **COVID-19 infection prevention and control risk management** This primer provides an overview of three widely used tools for investigating and responding to patient safety events and near misses. Tools covered in this primer include incident reporting systems, Root Cause Analysis (RCA), and Failure Modes and Effects Analysis (FMEA).
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-infection-prevention-and-control-risk-management-guidance>

- *Poster – Combined contact and droplet precautions*
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/infection-prevention-and-control-poster-combined-contact-and-droplet-precautions>





VISITOR RESTRICTIONS MAY BE IN PLACE

For all staff

Combined contact & droplet precautions*

In addition to standard precautions

Before entering room/care zone	At doorway prior to leaving room/care zone
<div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">1 Perform hand hygiene</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">2 Put on gown</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">3 Put on surgical mask</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">4 Put on protective eyewear</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">5 Perform hand hygiene</div> </div> <div style="display: flex; align-items: center;">  <div style="margin-left: 10px;">6 Put on gloves</div> </div>	<div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">1 Remove and dispose of gloves</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">2 Perform hand hygiene</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">3 Remove and dispose of gown</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">4 Perform hand hygiene</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">5 Remove protective eyewear</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">6 Perform hand hygiene</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">7 Remove and dispose of mask</div> </div> <div style="display: flex; align-items: center; margin-bottom: 10px;">  <div style="margin-left: 10px;">8 Leave the room/care zone</div> </div> <div style="display: flex; align-items: center;">  <div style="margin-left: 10px;">9 Perform hand hygiene</div> </div>

What else can you do to stop the spread of infections?

- Consider patient placement
- Minimise patient movement
- Appropriate bed allocation.

*e.g. Acute respiratory tract infection with unknown aetiology, seasonal influenza and Respiratory syncytial virus (RSV)

For more detail, refer to the Australian Guidelines for the Prevention and Control of Infection in Healthcare and your state and territory guidance.

- *Poster – Combined airborne and contact precautions*
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/poster-combined-airborne-and-contact-precautions>

VISITOR RESTRICTIONS IN PLACE

For all staff

Combined airborne & contact precautions

in addition to standard precautions

Before entering room/care zone

- 1

Perform hand hygiene
- 2

Put on gown
- 3

Put on a particulate respirator (e.g. P2/N95) and perform fit check
- 4

Put on protective eyewear
- 5

Perform hand hygiene
- 6

Put on gloves

At doorway prior to leaving room/care zone

- 1

Remove and dispose of gloves
- 2

Perform hand hygiene
- 3

Remove and dispose of gown
- 4

Leave the room/care zone
- 5

Perform hand hygiene (in an anteroom/outside the room/care zone)
- 6

Remove protective eyewear (in an anteroom/outside the room/care zone)
- 7

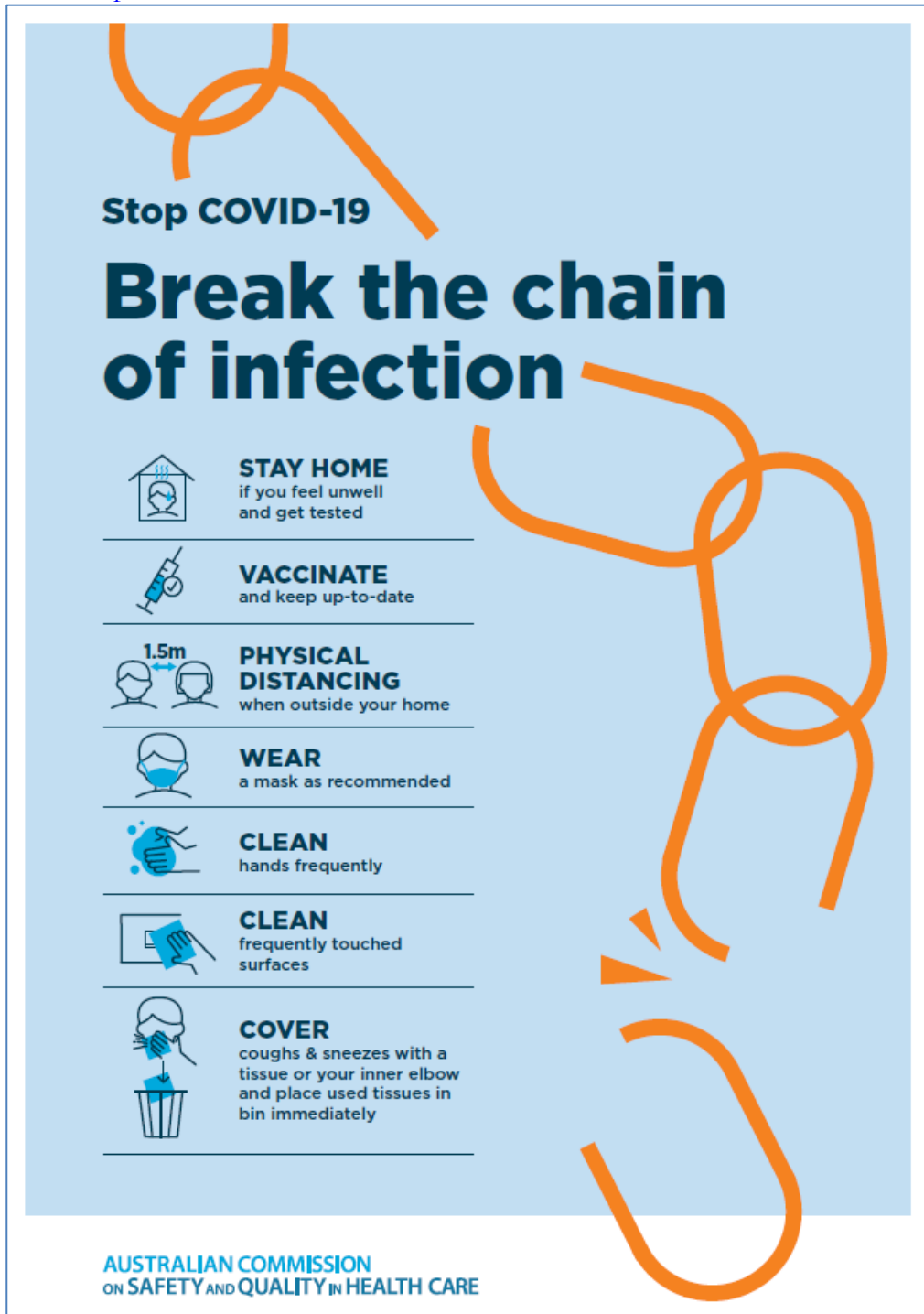
Perform hand hygiene (in an anteroom/outside the room/care zone)
- 8

Remove and dispose of particulate respirator (in an anteroom/outside the room/care zone)
- 9

Perform hand hygiene

KEEP DOOR CLOSED AT ALL TIMES

- *Environmental Cleaning and Infection Prevention and Control*
www.safetyandquality.gov.au/environmental-cleaning
- *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>
- *Stop COVID-19: Break the chain of infection* poster
<https://www.safetyandquality.gov.au/publications-and-resources/resource-library/break-chain-infection-poster-a3>



- *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>
- *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.

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, a COVID status monitor, a risk monitoring dashboard and evidence checks on a discrete topic or question relating to the current COVID-19 pandemic. There is also a ‘Living evidence’ section summarising key studies and emerging evidence on **COVID-19 vaccines** and **SARS-CoV-2 variants**. The most recent updates include:

- ***Eating disorders and COVID-19*** – What is the impact of the COVID-19 pandemic on the prevalence of eating disorders?
- ***Long COVID*** – What is the evidence on the prevalence, presentation and management of long-COVID?
- ***Oseltamivir (Tamiflu) use in healthcare settings*** – What is the evidence that use of oseltamivir in healthcare workers with a symptomatic influenza diagnosis result in an earlier return to work and reduced absenteeism? What is the evidence that use of oseltamivir in adults and children with symptomatic influenza reduces influenza transmission in health care settings?
- ***Alternative models of care for acute medical conditions*** – What is the evidence on alternative models of care for managing patients with acute medical conditions outside of emergency or inpatient hospital settings?
- ***Exercise and long COVID*** – Is exercise helpful in individuals with long COVID? Is post-exertional symptom exacerbation a risk in long COVID?
- ***Influenza and seasonal prophylaxis with oseltamivir*** – What is the place or evidence for seasonal influenza prophylaxis (such as taking oseltamivir for 10 to 12 weeks continuously) in healthcare and aged care settings?
- ***Rapid access models of care for respiratory illnesses*** – What is the evidence for rapid access models of care for respiratory illnesses, especially during winter seasons, in emergency departments?
- ***Current and emerging patient safety issues during COVID-19*** – What is the evidence on the current and emerging patient safety issues arising from the COVID-19 pandemic?
- ***Post-acute sequelae of COVID-19*** – What is the evidence on the post-acute sequelae of COVID-19?
- ***Emerging variants*** – What is the available evidence for emerging variants?
- ***Chest pain or dyspnoea following COVID-19 vaccination*** – What is evidence for chest pain or dyspnoea following COVID-19 vaccination?
- ***Cardiac investigations and elective surgery post-COVID-19*** – What is evidence for cardiac investigations and elective surgery post-COVID-19?

- ***Breathlessness post COVID-19*** – How to determine those patients who present with ongoing breathlessness in need of urgent review or intervention due to suspected pulmonary embolus?
- ***COVID-19 pandemic and influenza*** – What is the evidence for COVID-19 pandemic and influenza?
- ***Budesonide and aspirin for pregnant women with COVID-19*** – What is the evidence for the use of Budesonide for pregnant women with COVID-19? What is the evidence for aspirin prophylaxis for pre-eclampsia in pregnant women with a COVID-19 infection?
- ***COVID-19 vaccines in Australia*** – What is the evidence on COVID-19 vaccines in Australia?
- ***COVID-19 pandemic and wellbeing of critical care and other healthcare workers*** – Evidence in brief on the impact of the COVID-19 pandemic on the wellbeing of critical care and other healthcare workers.
- ***Surgery post COVID-19*** – What is the evidence for the timing of surgery, and outcomes following surgery, for people who have recovered from COVID-19?
- ***Disease modifying treatments for COVID-19 in children*** – What is the evidence for disease modifying treatments for COVID-19 in children?
- ***Mask type for COVID-19 positive wearer*** – What is the evidence for different mask types for COVID-19 positive wearers?
- ***Post acute and subacute COVID-19 care*** – What published advice and models of care are available regarding post-acute and subacute care for COVID-19 patients?
- ***Hospital visitor policies*** – What is the evidence for hospital visitor policies during and outside of the COVID-19 pandemic?
- ***Surgical masks, eye protection and PPE guidance*** – What is the evidence for surgical masks in the endemic phase in hospitals and for eyewear to protect against COVID-19?

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