AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# On the Radar

Issue 565
11 July 2022

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**On the Radar**
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**Information sheets for health service organisations and for nurses and doctors on carbapenemase-producing Enterobacterales**
https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/carbapenemase-producing-enterobacterales

The Commission published the updated *Recommendations for the control of carbapenemase-producing Enterobacteriaceae (CPE) - A guide for acute care health facilities* (the CPE Guide) in late 2021. The CPE Guide update follows increasing prevalence of CPE across Australia and recommends strategies to prevent, detect and contain CPE.

To support the implementation of the recommendations outlined in the CPE Guide, the Commission has also published a summary information sheet for health service organisations and an information sheet for nurses and doctors. These resources complement the CPE Guide and the Commission's existing CPE information sheet for patients and promotional infographic. All resources are available from the Commission's CPE webpage at https://www.safetyandquality.gov.au/our-work/infection-prevention-and-control/carbapenemase-producing-enterobacterales


**Journal articles**

*Disease burden, associated mortality and economic impact of antimicrobial resistant infections in Australia*
Wozniak TM, Dyda A, Merlo G, Hall L
The Lancet Regional Health – Western Pacific. 2022;27.

*Antimicrobial resistance: Designing a comprehensive macroeconomic modeling strategy*
Fernando R, McKibbin WJ
Washington D.C.: Brookings Institution; 2022. p. 30.

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| DOI | Wozniak et al https://doi.org/10.1016/j.lanwpc.2022.100521<br>Fernando and McKibbin https://www.brookings.edu/research/antimicrobial-resistance-designing-a-comprehensive-macroeconomic-modeling-strategy/ |
| Notes | A recent report from the Brookings Institution (Fernando and McKibbin) noted that in 2019 antimicrobial resistance (AMR) ') is a dominant and growing global health threat that led to 1.27 million deaths in 2019'. Wozniak et al report on AMR in Australia, estimating 'the AMR-associated health and economic impact caused by five hospital-associated AMR pathogens (*Enterococcus spp., E. coli, K. pneumoniae, P. aeruginosa* and *S. aureus*) in patients with a bloodstream, urinary tract, or respiratory tract infection in Australia in 2020.' They report that in 2021:<br>• '1,031 AMR-associated deaths (95% uncertainty interval [UI] 294, 2,615) from the five resistant hospital-associated infections in Australia.<br>• The greatest odds of dying were from respiratory infections (ceftazidime-resistant *P. aeruginosa*) and bloodstream infections, both resulting in high hospital and premature death costs.<br>• MRSA bacteraemia contributed the most to hospital costs (measured as bed-days) as patients with this infection resulted in additional 12,818 (95% UI 7246, 19966) hospital bed-days and cost the hospitals an extra $24,366,741 (95%UI $13,774,548, $37,954,686) per year.<br>• However, the cost of premature death from five resistant pathogens was $438,543,052, which was by far greater than the total hospital cost ($71,988,858). We estimate a loss of 27,705 quality-adjusted life years due to the five AMR pathogens.' |

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

*Recognizing and responding to clinical deterioration in adult patients in isolation precautions for infection control: a retrospective cohort study*
Berry D, Street M, Hall K, Sprogis SK, Considine J
International Journal for Quality in Health Care. 2022;34(2).

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| DOI | https://doi.org/10.1093/intqhc/mzac020 |
| Notes | Recognising and responding in a timely manner to clinical deterioration is an important aspect of acute care. However, when isolation precautions have been implemented for infection control this may pose a challenge in maintaining that careful observation. This retrospective cohort study was conducted across three sites of a large Australian health service and covered 634 adult patients who were admitted into isolation precautions within 24 h of admission from 1 July 2019 to 31 December 2019. The study found that 'One in eight patients experienced at least one episode of clinical deterioration during their time in isolation with most episodes of deterioration occurring within the first 2 days of admission. Timely Medical Emergency Team calls occurred in almost half the episodes of deterioration; however, the same proportion |

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| | (47.2%) of deterioration episodes resulted in no Medical Emergency Team activation'. It was also found that 'Patients who deteriorated during isolation for infection control were older (median age 74.0 vs 71.0 years, P = 0.042); more likely to live in a residential care facility (21.0% vs 7.2%, P = 0.006); had a longer initial period of isolation (4.0 vs 2.9 days, P = < 000.1) and hospital length-of-stay (median 4.9 vs 3.2 days, P = < 0.001) and were more likely to die in hospital (12.3% vs 4.3%, P < 0.001).' |

For information on the Commission's work on recognising and responding to deterioration, see https://www.safetyandquality.gov.au/our-work/recognising-and-responding-deterioration

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

*Satisfacción de pacientes y cuidadores familiares en unidades de cuidados intensivos de adultos: revisión de la literature*
*Satisfaction of patients and family caregivers in adult intensive care units: Literature Review*
Guerra-Martín MD, González-Fernández P
Enfermería Intensiva. 2021;32(4):207-219.

*Just Talk to Me – A Qualitative Study of Patient Satisfaction in Emergency Departments*
Haug M, Dahm M, Gewald HG, Georgiou A
Volume 290: MEDINFO 2021: One World, One Health – Global Partnership for Digital Innovation. Studies in Health Technology and Informatics ed2021. p. 385-389.

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| DOI | Guerra-Martín and González-Fernández https://doi.org/10.1016/j.enfi.2020.07.002<br>Haug et al https://doi.org/10.3233/SHTI220102 |
| Notes | While patient satisfaction has in some ways given way to patient experience and patient reported outcomes in recent years, it can be revealing.<br>Guerra-Martín and González-Fernández report on a Spanish study that reviewed the literature (in English and Spanish) on patient satisfaction and intensive care. From 760 identified studies, the review focused on 15 and found 'The factors that increased satisfaction are: good **communication** with professionals (n=5), the **quality of care** (n=4), and the **cleanliness and environment** of the units (n=2). The factors that produced dissatisfaction are: the **infrastructure** of the waiting room (n=5), inadequate **communication** (n=4), and the **involvement of families and patients in decision-making** (n=4). **Training** of professionals (n=5), **inclusion of the family** during the process of hospitalization (n=2) and **redesigning the waiting room** (n=2) are some of the suggestions for improvement.'<br>Haug et al is a study authored by academics in Germany and Australia that interviewed patients in Australian emergency departments (Eds) about their communication needs and experiences. These interviews demonstrate the importance of effectively communicating with patients about their care, their diagnosis and prognosis. This seems particularly true 'if patients show low health literacy' where the importance of feeling informed increases patient satisfaction (and presumably lowers patient anxiety) as 'It is important that patients feel informed as this increases patient satisfaction, even though they may not fully understand the delivered information.' |

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

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

*Improving diversity in study participation: Patient perspectives on barriers, racial differences and the role of communities*
Shea L, Pesa J, Geonnotti G, Powell V, Kahn C, Peters W
Health Expectations. 2022 [epub].

*Does racism impact healthcare quality? Perspectives of Black and Hispanic/Latino Patients*
Findling MG, Zephyrin L, Bleich SN, Tosin-Oni M, Benson JM, Blendon RJ
Healthcare. 2022;10(2):100630.

*Association of Patient and Family Reports of Hospital Safety Climate With Language Proficiency in the US*
Khan A, Parente V, Baird JD, Patel SJ, Cray S, Graham DA, et al
JAMA Pediatrics. 2022.

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| DOI | Shea et al https://doi.org/10.1111/hex.13554<br>Findling et al https://doi.org/10.1016/j.hjdsi.2022.100630<br>Khan et al https://doi.org/10.1001/jamapediatrics.2022.1831 |
| Notes | Communication and engagement are central to any patient's engagement with health care, but there can be barriers, including language. These articles all examine aspects of diversity and inclusion in health, including research and care delivery.<br>Shea et al recognise that historically many studies in health and medicine have had fairly narrow study populations. As they observe, 'The lack of racial/ethnic diversity in research potentially limits the generalizability of findings to a broader population, highlighting the need for greater diversity and inclusion in clinical research.' This qualitative study sought to examine potential motivators and barriers to study participation among a group of US participants. The authors report 'Barriers to study participation included: limited awareness of opportunities to participate in research, fears about changes in standard therapy, breaking cultural norms/stigma, religion-related concerns and mistrust of clinical research. Participants identified the importance of transparency by pharmaceutical companies and other entities to build trust and partnership and cited key roles that communities can play.' They also identified the 'need for pharmaceutical companies and other entities to authentically engage in strategies that build trust within communities to enhance recruitment among diverse populations.'<br>Findling et al report on the perspective Black and Hispanic/Latino patients in the USA on how racism influences the quality of health care (but the findings may be applicable for minority populations elsewhere). Based on a sample of 1003 U.S. Black and Hispanic/Latino households, the authors found that Black and Hispanic/Latino patients who had experienced racism in healthcare, reported more negative views on the quality of their care and lower trust in their clinicians. The authors urge that 'the important role of health professionals and healthcare institutions in perpetuating—and eliminating—racism in the provision of medical care. Racial inequities in healthcare are not inevitable, and by reducing racism in the provision of care, health professionals and healthcare institutions may improve their patients' trust and satisfaction with their healthcare quality.'<br>Khan et al look at the issue of proficiency in the dominant language, in this instance English in the USA, and how it impacts on speaking up or asking questions when something does not appear right. The paper reports on a cohort study of 533 hospitalised paediatric patients and families and found that 'compared with participants with English proficiency, those with limited English proficiency had significantly lower odds of freely speaking up, questioning decisions, and being unafraid to ask questions'. The authors stress that 'This disparity may contribute to higher hospital safety risk for patients with limited English proficiency. Dedicated efforts to improve communication with patients and families with limited English proficiency are necessary to improve hospital safety and reduce disparities.' |

*Medication-related Medical Emergency Team activations: a case review study of frequency and preventability*
Levkovich BJ, Orosz J, Bingham G, Cooper DJ, Dooley M, Kirkpatrick C, et al
BMJ Quality & Safety. 2022 [epub].

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| DOI | http://dx.doi.org/10.1136/bmjqs-2021-014185 |
| Notes | This Australian study examined Medical Emergency Team (MET) calls in order to better understand the incidence and preventability of medication-related Medical Emergency Team (MET) activations. This was a case review of 628 consecutive MET activations over a 3-week period at two acute, academic teaching hospitals in Melbourne, Australia. Of the 9439 admissions and 628 MET activations, 146 (23.2%) MET activations were medication related: an incidence of 15.5 medication-related MET activation per 1000 admissions. The study also found:<br>• 'Medication-related MET activations occurred a median of 46.6 hours earlier (IQR 22–165) in an admission than non-medication-related activations (p=0.001)<br>• this group also had more repeat MET activations during their admission (p=0.021, OR=1.68, 95% CI 1.09 to 2.59).<br>• A total of 92 of 146 (63%) medication-related MET activations were potentially preventable.<br>• Tachycardia due to omission of beta-blocking agents (10.9%, n=10 of 92) and hypotension due to cumulative toxicity (9.8%, n=9 of 92) or inappropriate use (10.9%, n=10 of 92) of antihypertensives were the most common adverse medication events leading to potentially preventable medication-related MET activations.' |

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

For information on the Commission's work on recognising and responding to deterioration, see
https://www.safetyandquality.gov.au/our-work/recognising-and-responding-deterioration

*International Journal for Quality in Health Care*
Volume 34, Issue 2, 2022

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| URL | https://academic.oup.com/intqhc/issue/34/2 |
| | A new issue of the *International Journal for Quality in Health Care* has been published. Articles in this issue of the *International Journal for Quality in Health Care* include:<br>• Evaluation of the association of **length of stay in hospital and outcomes** (Thang S Han; Paul Murray; Jonathan Robin; P Wilkinson ; D Fluck, C H Fry)<br>• Regulatory relationships of **demographic, clinical characteristics and quality of care for heart failure patients in southern China** (Rong Fu; Shaodan Feng; Qidong Chen; Yulan Lin ; Zheng Lin, Zhijian Hu)<br>• **Incident reporting reduction during the COVID-19 pandemic** in a tertiary Italian hospital: A retrospective analysis (Giulia Pauletti; Cristian Girotto; Giuseppe De Luca; Anna Maria Saieva)<br>• A qualitative study exploring **patient shadowing as a method to improve patient-centred care**: 10 principles for a new gold standard (Joanna Goodrich; Damien Ridge; Tina Cartwright<br>• **Accreditation and clinical outcomes**: shorter length of stay after first-time hospital accreditation in the Faroe Islands (Maria Daniella Bergholt; Christian Von Plessen; Søren paaske Johnsen; Peter Hibbert ; Jeffrey Braithwaite, Jan Brink Valentin, A M Falstie-Jensen) |

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| | • The future of **quality and accreditation surveys**: Digital transformation and artificial intelligence (Zuhal Cayirtepe; Figen Cizmeci Senel<br>• **Systemic resilience and COVID-19**: lessons from Taiwan (Victoria Y Wang)<br>• Rebooting effective **clinical supervision** practices to support healthcare workers through and following the COVID-19 pandemic (Priya Martin; Saravana Kumar; Esther Tian ; Geoff Argus; Srinivas Kondalsamy-Chennakesavan, Lucylynn Lizarondo, Tiana Gurney, David Snowdon)<br>• A simulation study on the association of HRO communication patterns and **surgical team performance** (Amanda Baty; Timothy I Matis; John Griswold)<br>• Global and regional burden and quality of care of **non-rheumatic valvular heart diseases**: a systematic analysis of Global Burden of Disease 1990–2017 (Mehrabi Nejad; Naser Ahmadi; Esmaeil Mohammadi; Mahya Shabani, A Sherafati, A Aryannejad, N Rezaei, A Ghanbari, M Yoosefi, A Aminorroaya, M Shabani, N Rezaei, T Salavati, B Larijani, S Naderimagham, F Farzadfar)<br>• The association between **women's empowerment and reproductive health care utilization** in Cameroon (Blandine Mokam; Christian Zamo Akono)<br>• Designing **clinical indicators for common residential aged care conditions and processes of care**: the CareTrack Aged development and validation study (Peter D Hibbert; Charlotte J Molloy; Louise K Wiles; Ian D Cameron ; Leonard C Gray, Richard L Reed, Alison Kitson, Andrew Georgiou, Susan J Gordon, Johanna Westbrook, Gaston Arnolda, Rebecca J Mitchell, Frances Rapport, Carole Estabrooks, G L Alexander, C Vincent, A Edwards, A Carson-Stevens, C Wagner, B Mccormack, J Braithwaite)<br>• Modelling the **effect of COVID-19 mass vaccination on acute hospital admissions** (Ross D Booton; Anna L Powell; Katy M E Turner; R M Wood)<br>• Development of a **quality assurance tool for intensive care units** in Lebanon during the COVID-19 pandemic (Märit Halmin; Ghada Abou Mourad; Adam Ghneim ; Alissar Rady; Tim Baker, Johan Von Schreeb)<br>• Development and validation of a **quality indicator system for outpatient service** in Shenzhen, China (Qian Lin; Horng-Shuh Hao; D Qin; D Zhang)<br>• An analysis of **complaints about hospital care** in the Republic of Ireland (Emily O'dowd; SinÉad Lydon; Kathryn Lambe; Akke Vellinga ; Chris Rudland, Elaine Ahern, Aoife Hilton, Marie E Ward, Maria Kane, Tom Reader, Alex Gillespie, David Vaughan, Dubhfeasa Slattery, Paul O'connor)<br>• Time to review **reflective practice**? (Terry Quilty; Lyn Murphy)<br>• **Nosocomial COVID**: the moral and clinical imperative for worldwide data collection and action (Fatima Junaid; Padmanabhan Badrinath)<br>• Developing **clinical care programs**: Experience from a Colombian clinical center (Alejandro De la torre; Carolina Ayola; A Franco; R González Molina)<br>• Rates of **underreported needlestick and sharps injuries among healthcare workers** in Turkey: in the light of Infection Control Committee data (Nesibe Korkmaz; Gönül Çiçek Şentürk; Asiye Tekin; Yunus Gürbüz ; Ganime Sevinç, Emin Ediz Tütüncü, İrfan Şencan)<br>• Development of a **professional competency framework for Australian sonographers**—perspectives for developing competencies using a Delphi methodology (Jessie Childs; Kerry Thoirs; Ann Quinton ; Brooke Osborne; Christopher Edwards, Paul Stoodley, Paul Lombardo, Sandra Mcdonald, Debbie Slade, Amanda Chandler, Lucy Taylor, J Long, K Pollard, T Halligan) |

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| | • Recognizing and responding to **clinical deterioration in adult patients in isolation precautions for infection control**: a retrospective cohort study (Debra Berry; Maryann Street; Kylie Hall; Stephanie K Sprogis, J Considine)<br>• **How safe is virtual healthcare?** (Reema Harrison ; Elizabeth Manias)<br>• Editorial: **Cluster randomized controlled trial**: A matter of independence (Gopalakrishnan Netuveli) |

*Health Affairs*
Volume 41, Number 7, July 2022

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| URL | https://www.healthaffairs.org/toc/hlthaff/41/7 |
| Notes | A new issue of *Health Affairs* has been published with the theme "Type 2 Diabetes & More". Articles in this issue of *Health Affairs* include:<br>• A New Way To Support **Frequent Emergency Department Visitors** (David Tuller)<br>• **Diabetes And The Fragmented State Of US Health Care** And Policy (Puneet Kaur Chehal, Elizabeth Selvin, Jennifer E DeVoe, Carol M Mangione, and Mohammed K Ali)<br>• **Care Management For Patients With Type 2 Diabetes**: The Roles Of Nurses, Pharmacists, And Social Workers (Thomas S Bodenheimer and Rachel Willard-Grace)<br>• Modernizing **Diabetes Care Quality Measures** (David H Jiang, Patrick J O'Connor, Nathalie Huguet, Sherita Hill Golden, and Rozalina G McCoy)<br>• **Nonmedical Interventions For Type 2 Diabetes**: Evidence, Actionable Strategies, And Policy Opportunities (Leonard E Egede, Rebekah J Walker, Sebastian Linde, J A Campbell, A Z Dawson, J S Williams, and M N Ozieh)<br>• The **Diabetes Prevention Gap** And Opportunities To Increase Participation In Effective Interventions (Maria L Alva, Rosette J Chakkalakal, Tannaz Moin, and Karla I Galaviz)<br>• Can **Alternative Payment Models And Value-Based Insurance Design Alter The Course Of Diabetes** In The United States? (Sabrina Wang, George Weyer, Obidiugwu Kenrik Duru, Robert A Gabbay, and Elbert S Huang)<br>• Disparities In **Diabetes-Related Lower Extremity Amputations** In The United States: A Systematic Review (Hamlet Gasoyan, Shirin R Hussain, W Geoffrey Wright, and David B Sarwer)<br>• **Health Care Spending Effectiveness**: Estimates Suggest That Spending Improved US Health From 1996 To 2016 (Marcia R Weaver, Jonah Joffe, Michael Ciarametaro, Robert W Dubois, Abe Dunn, Arjun Singh, Gianna W Sparks, Lauryn Stafford, Christopher J L Murray, and Joseph L Dieleman)<br>• Effect Of **Nonpharmaceutical Interventions On COVID-19** Cases And Deaths In Brazil (Louise B Russell, Lara Livia Santos da Silva, Rodrigo Fracalossi de Moraes, Risha Gidwani, Paula M Luz, and Cristiana M Toscano)<br>• **Phantom Networks**: Discrepancies Between Reported And Realized **Mental Health Care Access** In Oregon Medicaid (Jane M Zhu, Christina J Charlesworth, Daniel Polsky, and K John McConnell)<br>• How Phantom Networks And Other Barriers Impede Progress On **Mental Health Insurance Reform** (Howard H Goldman)<br>• **Phantom Networks** Prevent Children And Adolescents From Obtaining The **Mental Health Care** They Need (Brett Dolotina and Jack Turban) |

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| | • Hospital And Regional Characteristics Associated With **Emergency Department Facility Fee Cash Pricing** (Morgan A Henderson and Morgane C Mouslim)<br>• Local Supply Of **Postdischarge Care Options Tied To Hospital Readmission Rates** (Kevin N Griffith, David A Schwartzman, Steven D Pizer, Jacob Bor, Vijaya B Kolachalama, Brian Jack, and Melissa M Garrido)<br>• **Food Insecurity, Missed Workdays, And Hospitalizations Among Working-Age US Adults With Diabetes** (Joshua M Weinstein, Anna R Kahkoska, and Seth A Berkowitz)<br>• Catastrophic Spending On **Insulin In The United States**, 2017–18 (Baylee F Bakkila, Sanjay Basu, and Kasia J Lipska) |

*BMJ Quality & Safety* online first articles

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| URL | https://qualitysafety.bmj.com/content/early/recent |
| Notes | *BMJ Quality &Safety* has published a number of 'online first' articles, including:<br>• **Medication-related Medical Emergency Team activations**: a case review study of frequency and preventability (Bianca J Levkovich, Judit Orosz, Gordon Bingham, D James Cooper, Michael Dooley, Carl Kirkpatrick, Daryl A Jones)<br>• Editorial: **Medication review in hospitalised older people**: what have we learnt? (Nina Lee Barnett, Lelly Oboh)<br>• Editorial: **Medication safety in nursing home patients** (David W Bates, Jonathan Zebrowski)<br>• **Socioeconomic deprivation and ethnicity inequalities in disruption to NHS hospital admissions during the COVID-19** pandemic: a national observational study (Max Warner, Samantha Burn, George Stoye, Paul P Aylin, Alex Bottle, Carol Propper) |

**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 are:

- Clinical Guideline CG191 ***Pneumonia*** *in adults: diagnosis and management*
  https://www.nice.org.uk/guidance/cg191
- NICE Guideline NG223 *Social, emotional and mental* ***wellbeing in primary and secondary education***
  https://www.nice.org.uk/guidance/ng223

### *[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:

- *Schedule of Visits and Televisits for* ***Routine Antenatal Care***
  https://effectivehealthcare.ahrq.gov/products/schedule-visits-antenatal-care/research

**COVID-19 resources**

https://www.safetyandquality.gov.au/covid-19

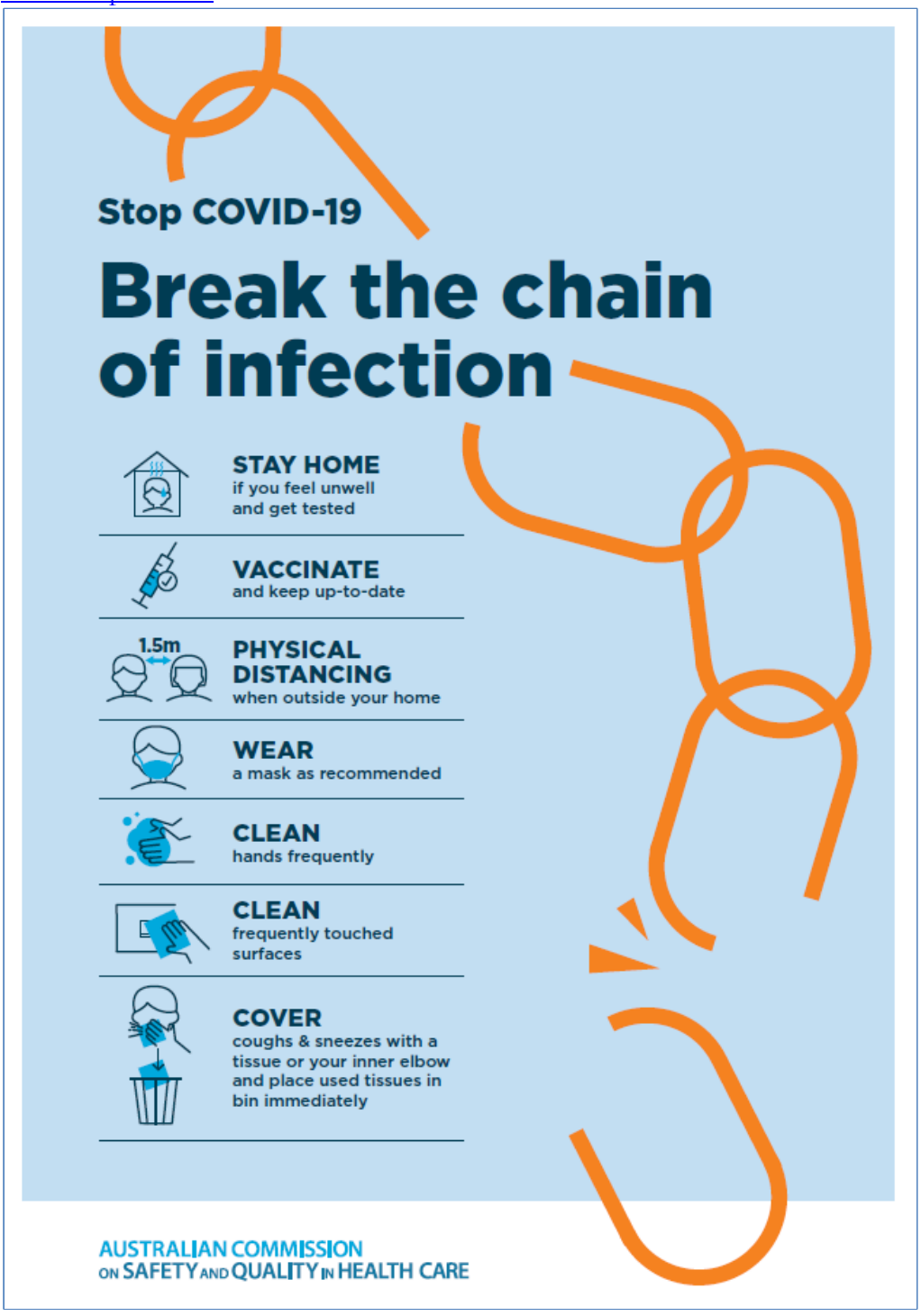
The Australian Commission on Safety and Quality in Health Care has developed a number of resources to assist healthcare organisations, facilities and clinicians. These and other material on COVID-19 are available at https://www.safetyandquality.gov.au/covid-19

These resources include:

- *OVID-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

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

- *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:

- ***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?