



AGED CARE AND DISABILITY SERVICES

Message from Our Team

Dear Colleagues,

Welcome to the Spring edition of our newsletter. Spring is just around the corner and many of us will be welcoming the warmer weather which will hopefully see a decrease in the continuing current high acute respiratory illness activity in the community.

This is again a bumper issue with many interesting articles. A common theme runs through some of them identifying that adequate IPC preparation, including education of all HCWs, clear and detailed policies and procedures, adequate resources and consistent leadership is needed to successfully manage infection outbreaks in aged and disability care settings. I think you will identify with some of the article findings. An article that relates to this also talks about the importance of adequate training for environmental services staff. They play an important role in the safe care of vulnerable individuals.

An article that resonated with our team when conducting IPC risk assessments discusses Safe Injection, Infusion, Medication vial, and Point-of-care Testing Practices in Health Care. Some key issues that we often identify are among the recommendations made.

As usual, links are provided with each item throughout the newsletter for easy access to the full articles. We would welcome any feedback about the newsletter, or suggestions for other things you would like to see included in future editions.

Until next time, look after yourselves, stay well and keep warm.

In This Issue We Have

Immunisation Updates	Spotlight Organism	In The Literature	Items of Interest
Feature Article	In Focus	What's New	Upcoming Events

IMMUNISATION UPDATES

National Immunisation Strategy for Australia 2025–2030

The Australian Department of Health, Disability and Ageing has released the National Immunisation Strategy for Australia 2025 – 2030 setting a framework for achieving the vision for a healthier Australia through immunisation. The strategy provides a roadmap to increase and sustain immunisation rates in Australia over the next 5 years to reduce the impact of vaccine-preventable diseases through high uptake of safe, effective, and equitable immunisation across the lifespan of the Australian population.

The strategy takes a holistic approach and is built on 6 priority areas:

- Improving access to immunisation
- Building trust and understanding of immunisation within communities
- Enhancing data use to target immunisation strategies and monitor performance
- Strengthening the immunisation workforce
- Harnessing new technologies to respond to evolving vaccine landscapes
- Implementing sustainable reform in vaccine program governance and accountability

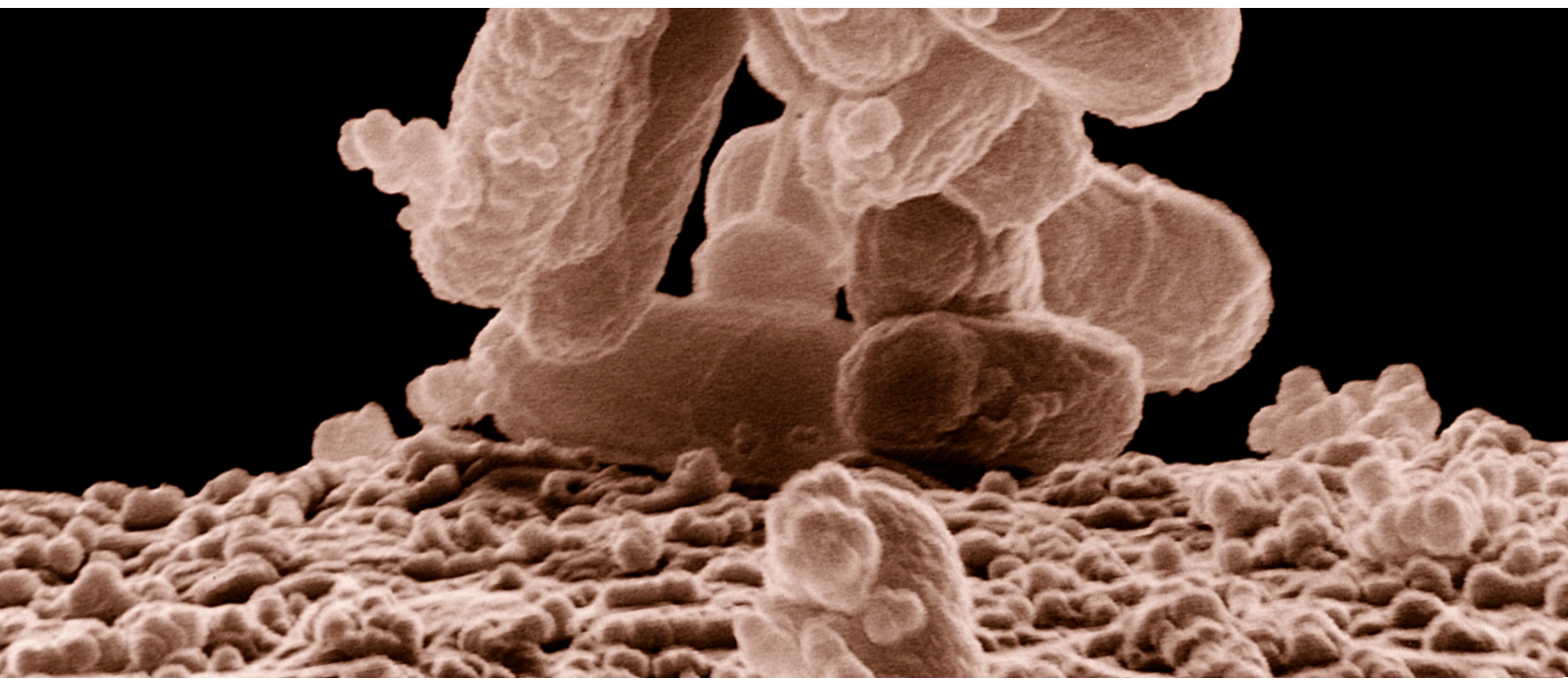
For more details, [access the full strategy here](#).

Vaccine Update 446 - COVID-19 leading cause of mortality from Acute Respiratory Illness in Australia 2023-2025

The World Health Organisation (WHO) recently released a report on the Independent assessment of origins of COVID-19. The report identified no evidence that XFG, a COVID-19 variant, leads to more severe outcomes than other circulating variants, and that current COVID-19 vaccines are expected to remain effective in preventing severe disease. The report also shows that COVID-19 disease remains the leading cause of mortality from acute respiratory infection in Australia across the 2023 – 2025 period.

Protection from COVID-19 vaccination wanes over time. Vaccine boosters can strengthen the immune system and improve the duration of protection from severe disease caused by COVID-19. The WA Department of Health urges vaccination for people at highest risk of severe outcomes from COVID-19 infection, including those living in residential aged care. ***Are your residents up to date with their COVID-19 vaccinations?***

Read further details [HERE](#)



Spotlight Organism

Escherichia coli (E. coli)

What?

E. coli is a gram-negative, facultative, rod-shaped, coliform bacteria that commonly lives in the gastrointestinal tract (gut) of healthy people, and helps you digest your food. In elderly people *E. coli* accounts for a high percentage of urinary tract infections, especially in women.

Risk factors for UTIs:

- **Female anatomy:** a woman's urethra is located next to the vagina and anus, making it easy for gut bacteria to move into the urinary tract. For this reason, UTIs are more common in women.
- **Improper wiping following a bowel movement:** wiping from back to front after a bowel movement, can drag *E. coli* (and other gut organisms) directly to the urethra.
- **Urine/Faecal incontinence:** may mean that urine/faecal matter is left in contact with the urethra, especially if incontinence pads are worn.
- **Menopause:** after menopause, a decline in circulating oestrogen causes changes in the urinary tract tissue which can increase the risk of UTI's.
- **Catheter Use:** both indwelling and intermittent catheters provide a direct access into the bladder and increases the risk of UTIs.
- **A suppressed immune system:** diabetes and other diseases can impair the immune system increasing the risk of UTIs. Age related declining immunity is also a factor.
- **A recent urinary tract procedure:** urinary tract surgery or examination involves the introduction of instruments into the bladder, and may cause tissue damage, both increasing the risk of a UTI.

Symptoms of a UTI:

UTIs don't always cause symptoms. When they do, they may include:

- A strong urge to urinate that doesn't go away
- A burning feeling when urinating
- Urinating often, and passing small amounts of urine
- Urine that appears red, bright pink or cola-coloured – signs of blood in the urine
- Pelvic pain, in women – especially in the center of the pelvis and around the area of the pubic bone

Note: Strong-smelling urine may indicate dehydration – does not require investigation or treatment unless present with other localised symptoms

Note; Urine that looks cloudy may also indicate dehydration - does not require investigation or treatment unless present with other localised symptoms

In older adults, UTIs may be overlooked or mistaken for other conditions. Confusion, a decline in mental acuity, and falls do not indicate the person has a UTI.

Asymptomatic bacteriuria (no localised signs or symptoms of a UTI and a positive urine culture) is common in the elderly, and should NOT be investigated and/or treated.

Complications of UTIs:

- Repeated infections, defined as two or more UTIs within 6 months, or 3 or more within a year.
- Permanent kidney damage from an untreated UTI.
- A narrowed urethra in men from repeated infections of the urethra.
- Sepsis, potentially life threatening, especially if the infection travels up to the kidneys.
- Clostridioides *difficile* (*C. diff*) infection from exposure to repeated antibiotics.
- Antimicrobial resistance from antibiotic overuse and misuse.

Detection of UTIs:

Dipstick testing alone is NOT a reliable diagnosis of a UTI. Do not perform a dipstick urinalysis if there are no localised signs and symptoms of a UTI.

- If the clinical probability of a UTI is moderate to high (e.g. localised signs and symptoms are present), a negative result on dipstick testing largely excludes a UTI.
- If the clinical probability of a UTI is low, the usefulness of a positive result is questionable. Given the prevalence of asymptomatic bacteriuria in the resident population, dipstick results are equally likely to be positive even if the resident does not have a UTI.

If localised signs and symptoms are present and urinalysis is positive for nitrite, blood, protein and/or leukocytes, a UTI is possible (but not confirmed) and a urine sample, either catheter specimen of urine (CSU), mid-stream urine (MSU) or clean catch, should be sent to pathology for microscopy, culture and sensitivity (MC&S) testing.

Prevention and Treatment:

- Drink plenty of liquids, especially water. Drinking water helps dilute the urine. That leads to urinating more often – allowing bacteria to be flushed from the urinary tract before an infection can begin.
- Try cranberry juice. Studies that look into whether cranberry juice prevents UTIs aren't final. However, drinking cranberry juice is likely not harmful.
- Wipe from front to back. Do this after urinating and after a bowel movement. It helps prevent the spread of bacteria from the anus to the vagina and urethra.
- Change incontinence pads frequently.
- Avoid potentially irritating feminine products. Using them in the genital area can irritate the urethra. These products include deodorant sprays, douches and powders.

IN THE LITERATURE

The experiences and roles of infection prevention and control (IPC) professionals working in residential care facilities during global outbreaks: An integrative review

Residential aged care facilities (RACF) are high risk settings delivering care to residents with chronic health conditions/co-morbidities, age-related immune function decline, and shared living spaces which all increase the risk of disease transmission. To reduce RACF outbreaks in Australia, the government issued a directive in late 2020 requiring all RACF to have an on-site IPC Lead to provide clinical leadership in IPC. This review aims to evaluate the existing literature on the roles and experiences of IPC Leads who worked in RACF during the pandemic to inform future practice.

Following assessment against the selection criteria, seven articles were evaluated. Three key themes emerged: Contextual and Organisational factors; Operational Strategies and Challenges, and Influences and Outcomes.

Contextual and Organisational factors: Contextual factors included residents sharing rooms, limited options to cohort sick residents, resident-related issues such as dementia making isolating/cohorting difficult, physical proximity and shared amenities. Staffing challenges such as pre-existing staff shortages, incomplete staff cohorting, limited resources such as PPE and testing kits, and insufficient time allocated to IPC Leads and activities.

Organisational factors: Strong leadership and support were vital incorporating efficient training and supervision of staff. Leadership ensuring clear and concise IPC training to enhance staff understanding and motivation and role-modelling were important. Staff tend to follow those in leadership positions. Respect and trust in management declines when local leaders failed to model best practice. Clear, comprehensive organisational policies and guidelines were required to guide IPC Lead's responses, however insufficient guidance left IPC Leads struggling to train staff and develop evidence-based approaches. Switching recommendations/practices midway through an outbreak caused staff confusion and mistrust.

Operational Strategies and Challenges: Some facilities had delayed responses, driven by deficient practices and overconfidence in outbreak preparedness. Cohorting protocols were indispensable however effective implementation was impacted by space limitations, and a dedicated, trained IPC Lead is a critical element in outbreak preparedness. Widespread issues with PPE use/supply, staffing and workforce management occurred. There was a strong correlation between the highest IPC breach rates and failure to comply with PPE, mask and transmission-based precautions requirements. Maintaining adequate PPE supplies, a shortage of IPC trained personnel and HCW turnover impacted the ability to consistently cohort staff. Evolving guidance and conflicting recommendations were recurrent themes. Frequent shifts in directives on reporting, isolation, testing and visitations occurred. Occupational health and safety issues emerged due to PPE shortages, emphasising the need to prioritise measure to minimise risk to staff.

Influences and Outcomes: Perceptions of the importance of IPC shifted during the pandemic, but the focus on acute care meant that residential care was sometimes overlooked, and there was a lack of standardised educational benchmarks for IPC Leads working in RACF. Whilst Australia currently mandates that each RACF must have an IPC Lead who has completed an identified course in IPC, a structured credentialling process involving mandatory minimum qualifications and periodic recertification could ensure that IPC Leads are best equipped going forwards. Effective communication strategies and comprehensive education and training programs are integral components that shape the readiness of a RACF for pandemics. The issues IPC Leads faced during the COVID-19 pandemic have strong parallels to those faced during the H1N1 pandemic a decade earlier, emphasising a systemic failure to adapt.

Read the full article [HERE](#)

Educational Needs for Infection Prevention and Control (IPC) During Outbreaks: A qualitative study with health workers in Sri Lanka

Protecting the health workforce is essential to health systems resilience for emerging infectious diseases (EID) outbreaks. Healthcare workers (HCWs) in low and middle income countries (LMICs) must be protected before, during and after emergencies. During epidemics and pandemics, HCWs carry a significant physical, social, and emotional burden caring for patients during complex and prolonged public health emergencies. Yet HCWs in many LMICs lack the resources and up-to-date training to consistently and safely carry out these responsibilities during crises.

This study explored healthcare workers (HCWs) perceptions of IPC guidelines and training needs for managing the COVID-19 pandemic in Sri Lanka. This study is part of a larger study which aims to

create role specific IPC guidelines for HCWs in LMICs.

Sixteen semi-structured interviews were conducted among hospital and public health HCWs including physicians, nurses, midwives, and support staff (e.g. cleaning services).

Some of the issues identified included:

- Insufficient resources, including PPE
- Guidance on IPC measures, including type of PPE required and isolation requirements, are often evolving and not yet contextualised to the available resources in LMICs
- During public health emergencies: resource rationing, HCW illness and onboarding of new and different types of HCW often leads to task shifting
- Newly formed teams, taking on new roles and tasks require guidance and focussed training on IPC best practices
- Whilst HCWs in clinical settings are often conceptualized as doctors, nurses and allied health professionals, outbreaks require a broadening of who is on the front line
- Support staff (e.g. cleaning staff) also need comprehensive IPC training to safely carry out their tasks, which are essential to giving care.

The COVID-19 pandemic highlights the importance of multi-modal training, testing and easy access to all training material. The findings illustrate the need for a tailored approach to IPC education based on identified overall and key specific needs (e.g. training support staff). Education on IPC must be ongoing and extended to all HCWs to benefit not only emergency preparedness, but other health system goals including patient safety and preventing antimicrobial resistance.

This study has lessons for all types of health service providers.

Read the full article [HERE](#)

Optimizing Training for Environmental Services Staff: A Critical Component of Patient Safety and Infection Control

Effective environmental services (EVS) are critical in maintaining a safe and healthy health care environment. Properly trained housekeeping staff are essential in preventing healthcare associated infections (HAIs). Additionally, EVS leaders must possess supervisory skills and advanced knowledge of cleaning protocols to ensure high hygiene standards.

Proper training equips housekeeping staff with the skills to clean and disinfect effectively, reducing microbial loads on surfaces and minimising infection risks. Key aspects of training should include:

- Understanding pathogen transmission, including how pathogens spread and which surfaces are most likely to harbour infectious agents.
- Proper use of cleaning agents, emphasising appropriate selection, dilution and application, and ensuring compliance with manufacturer's guidelines.
- Personal Protective Equipment (PPE): selecting appropriate PPE, correct donning, doffing and disposal to protect themselves and prevent cross-contamination.

Evidence suggests enhanced cleaning protocols and staff education significantly reduce the incidence of HAIs. Inadequate cleaning and disinfection can lead to unsafe environments, putting patients, staff and visitors at risk. Effective training prevents accidents and infections, and fosters a culture of accountability and professionalism.

EVS leaders play a pivotal role in ensuring the effectiveness of EVS teams. Properly trained leaders provide effective oversight, motivation and guidance to their teams.

The economic impacts of proper training yields substantial economic savings for health care facilities. Effective training reduces the costs associated with HAIs by preventing HAIs and minimising hospital readmissions (and admissions from aged care facilities). Trained staff also improve operational efficiency, reduce turnover rates and the need for corrective actions.

A robust training program should include:

- Initial comprehensive orientation.
- Ongoing education and regular competency assessments.
- Tailored modules to address specific needs such as biohazard handling.
- Feedback mechanisms to identify gaps in training and opportunities for improvement.

In summary, investing in the professional development of housekeeping staff protects patients, and staff, and delivers significant economic and reputational benefits.

Read the full article [HERE](#)

Safe Injection, Infusion, Medication vial, and Point-of-care Testing Practices in Health Care

This Association for Professionals in Infection Control and Epidemiology (APIC) position paper provides updated evidence-based guidance on safe injection, infusion, vials and point-of-care testing, and addresses the infection risks associated with these practices.

A review of current literature published since 2015 found an additional 22 published outbreaks associated with unsafe injection, infusion, point-of-care, or medication vial practices in the United States. Infections included bacteraemia, viremia, or septic arthritis in over 200 patients. Most outbreaks occurred in outpatient ambulatory settings. Additionally, the American Centres of Disease Control (CDC) reported that from 2008 through 2019, 79% of Hepatitis B (HBV) or Hepatitis C (HCV) outbreaks in long term care facilities were associated with infection prevention and control (IPC) breaches that occurred during blood glucose point-of-care testing procedures.

Some of the issues highlighted by this study were:

- Medication preparation outside a pharmacy without adequate environmental controls;
- Medication preparation near sinks;
- Inappropriate storage on intravenous (IV) solutions;
- Improper labelling and storage of drawn-up saline flushes, and the indefinite storage of these flushes in plastic drawers;

- Drawing up multiple doses for different patients from a single bulk dose pharmacy vial without the correct environmental controls for compounding sterile preparations, including not scrubbing the diaphragm with sterile alcohol prior to each entry;
- Storing syringes and needles outside their original packaging;
- Lack of disinfection of IV hub/port prior to using for IV administration;
- Single dose vials used as multidose vials;
- Lack of hand hygiene products available in the medication preparation room; and
- Reuse of blood glucose monitors between patients without disinfection.

APIC recommends utilizing aseptic technique for medication preparation:

- DO—Store and prepare medications and supplies in a clean area, on a clean surface, away from sinks or other water sources.
- DO—Perform hand hygiene before and after accessing supplies, handling vials and IV solutions, and preparing medications.
- DO—Use aseptic technique in all steps of medication preparation and administration (ie, medication vial use, including vaccine preparation, reconstituting powder medication vials in a medication area due to instability if premixed, parenteral medication administration, injections, and IV contrast preparation).
- DO—Disinfect IV hubs/ports and vial diaphragms (septum) with sterile 70% alcohol using friction for 15 seconds, and allow to dry prior to each entry, which includes after removing the cap of the vial, as the cap is considered only a dust cover.
- DO—Discard all opened vials, IV solutions, syringes, and unused prepared medications involved in an emergency.
- DO—Avoid contacting sterile drugs and sterile areas of devices and containers with nonsterile objects, secretions, or particles shed from personnel.
- DO—follow the manufacturer’s Instructions for Use (IFU) for storage recommendations of needles, syringes and medications. Only open immediately prior to use.
- DO—Provide training and oversight on using medication pens (e.g. Insulin). Attach the resident label to the pen, not the packaging, which could contain the wrong pen.
- DO—Use PPE in accordance with standard precautions.

Aseptic technique refers to properly handling, preparing, and storing medications and injection equipment or supplies to prevent microbial contamination. It is imperative that the HCP who prepares, administers, and stores the medication is knowledgeable and educated on the aseptic technique.

When performing Point-of-Care testing (e.g. blood glucose monitoring):

- Ensure both training and competency on the available device(s).
- Where possible, blood glucose meters should be assigned to an individual resident (i.e. single resident use), and not shared.
- If single resident use glucometers is not possible, the glucometer should be cleaned and disinfected between every resident’s use.

Read the full article [HERE](#)

ITEMS OF INTEREST

Religious influences on infection prevention and control practices in healthcare settings: A scoping review

Whilst evidence-based infection prevention and control (IPC) interventions are widely implemented across different healthcare settings, their implementation may be influenced by religious factors. This scoping review examined thirteen articles to assess the influence that religious factors have on IPC practices amongst healthcare workers (HCWs).

Thirteen articles were reviewed, and came from the United Arab Emirates (3), Iran (2), Libya (1), Lebanon (1), the United Kingdom (2), Switzerland (1), Brazil (1), Uganda (1) and Zambia (1). Three main themes were identified: religious rituals and influence, use of alcohol, and bare-below-the-elbows principle.

Religious rituals and influence: handwashing is identified as an established ritual practice in many religions, and may be an enabler of hand hygiene compliance and work to promote and reinforce hand hygiene. The wearing of PPE such as masks, was found to be something that was enabled by the frequent use of face and head coverings, particularly in the Muslim HCW population.

Use of alcohol: Buddhism, Hinduism and Islamism all prohibit the use of recreational alcohol, but allow its use in medical situations. However some HCW who practice these faiths may not be comfortable with using ABHR. This can potentially be a barrier to hand hygiene compliance.

“Bare Below the Elbows (BBE)”: This principle may conflict with Islamic dress codes where covering the arms and dressing modestly is required, and may be a barrier to BBE compliance.

The finding of this review identified that religious factors can be both enablers and barriers to IPC practices and have direct implications for healthcare practices and policies. More inclusive policies and culturally sensitive educational programs that address the specific concerns of different faith communities and respect religious and cultural beliefs whilst still promoting effective IPC measures is required. These measures will contribute to better healthcare outcomes and a more inclusive healthcare environment.

Read the full article [HERE](#)

What's the Point of Quality and Safety Auditing in Healthcare if Nurses Don't Use Data to Drive Improvement?

Clinical audits are vital tools for improving quality and safety. They are designed to identify care gaps, inform practice improvement, and ensure accountability. Yet, in practice, the utility of audits are often limited by poor feedback mechanisms, redundancy and workforce disengagement. Nurses, in particular, frequently report audit fatigue and frustration when the same data are reviewed repeatedly without visible change. This disconnect between data collection and clinical improvement raises an important question: *Are we auditing for improvement, or auditing for auditing's sake?*

Undertaking clinical audits have been a hallmark of quality under the healthcare accreditation standards for the Australian Commission for Quality and Safety in Healthcare. The National safety and Quality Health Service (NSQHS) Standards aim to improve the quality of care for patients in healthcare settings. Most healthcare services have developed schedules and reporting systems to routinise clinical audit timelines and the documentation forms part of the facility's accreditation.

Audit topics should focus on high-risk, high-volume, high-cost care activities, or where there are levels of clinical variation. Audit and feedback can help improve professional practice and system performance, however health services often fail at the "feedback" stage.

Significant barriers to the effective use of audit data exists, including lack of awareness or understanding of the importance of audits, misinterpretation of data, a lack of incentivisation, time, skills or motivation to use data, or system-related issues such as inaccurate data, poor data infrastructure, or systemic reporting of data into quality committees that are beyond unit level.

The overuse of audits can contribute to activities perceived as consuming time and resources without delivering clear benefits to patient safety or clinical outcomes, and quality improvement activities to address clinical issues often default to the "education will fix it" option and plug the gaps with ad-hoc or inservice education (56% of response interventions in a recent Cochrane study), without necessarily addressing the issues.

Auditing is key in identifying risks and informing safer clinical practice, however nursing time is finite and there is a need for greater strategic thought on clinical auditing to reduce over auditing whilst failing to engage and act on data.

Read the full article [HERE](#)

FEATURE ARTICLE

Analysis of Infection Prevention and Control (IPC) documentation in residential aged care based on a behaviour specification framework

Performing effective infection prevention and control (IPC) practices such as hand hygiene and appropriate use of gloves and masks is especially important to protect older people living in residential aged care facilities (RACF) from communicable pathogens. Competing priorities of RACF staff and workforce shortages in the sector can impact IPC practices. Previous data suggests that compliance with IPC guidelines, including local policies and procedures tailored to the RACF is generally low. It is important to better understand why, to inform changes to support and guide improvement. Although well specified documents are not the only solution for improving IPC practices, it is an important component of a multi-faceted approach to optimising appropriate IPC behaviours among RACF staff.

This analysis looked at the local policies and procedures of 8 residential care providers and the Australian Guidelines for the Prevention and Control of Infection in Healthcare using a behaviour specification framework. The study aimed to compare IPC behaviours and their specificity. Facilities were eligible to participate in this study if they had a registered or enrolled nurse onsite who had completed or commenced foundational IPC training, so called IPC Leads. Local policies and procedures were obtained from the eight RAC providers between July 2022 and February 2023. The author's expectations was that the level of specificity in organisational level documents would be higher, i.e. more detailed than the national level, given that local documents are developed for a specific setting and workforce.

The analysis found that whilst there was some overlap of behavioural statements in the national guidelines and local policies and procedures, IPC statements were generally not well specified in either the national guideline or local document. Of the 63 behavioural statements in the guideline relating to hand hygiene and appropriate use of gloves and masks, only 8 statements were mentioned by all residential care providers. Twelve statements were mentioned in local policies and procedures but not mentioned in the guideline and 2 statements mentioned locally seemed to conflict with the guideline.

In conclusion, the authors found that local policies and procedures need to be more aligned with national guidelines to reflect the evidence base. Once this alignment is in place, the specificity and

actionability of the local documents should be increased to inform staff of the IPC behaviours required at their specific organisation/facility.

It is acknowledged that whilst having clear and less open policies and procedures could help more consistent application of the desired behaviours, it does not necessarily mean that staff will read them and act upon them. Policies and procedures on their own will not change practice. Communicating the content of these documents to staff, and having implementation strategies such as audits and feedback, or educational meetings, in place is important.

Read the full article [HERE](#).

IN FOCUS

ACIPC is calling for immediate action as COVID-19 outbreaks surge in residential aged care

Aged care facilities are currently experiencing a concerning rise in COVID-19 outbreaks, with case numbers steadily rising since May. Reports in July identified 241 active outbreaks, with 1159 residents and 438 staff testing positive, and 138 resident deaths reported in June alone. Whilst praising infection prevention and control (IPC) professional's response in managing high levels of outbreaks, the College is urging health authorities to strengthen measures beyond vaccination with broader IPC measures including highlighting the need for improved air quality, access to personal protective equipment (PPE), and reinforced environmental controls. The risk of transmission in aged care is exacerbated by shared communal spaces, poor ventilation, increased visitor access, and the relaxation of key IPC strategies.

ACIPC is calling for a coordinated national response to include:

- Improved access to essential resources including PPE (particulate filter respirators), rapid antigen and PCR testing, and antiviral treatment.
- Engineering and environmental controls, including improved ventilation and air filtration across all health and aged care settings.
- Continued community engagement in prevention strategies: vaccination, appropriate mask use, testing when appropriate, and staying home when unwell.

The expertise of IPC professionals is essential to safeguard the health and well-being of residents and staff, and must be prioritised and supported by aged care providers.

Read the full media release [HERE](#)

Infection Prevention and Control (IPC) Lead Training and Reporting

From 1 August, training and reporting requirements have changed for IPC Leads. Changes include:

- IPC Leads will no longer need to complete COVID-19 training modules as part of their specialist training. Instead they will need to complete interim training on the Aged Care Quality and Safety Commission's [online learning platform](#).
- Providers will no longer need to report IPC Lead details. This is to help reduce the administrative burden. Providers will still need to keep records as required under the [Records Principles 2024](#).

Learn more about [IPC training and reporting requirements](#).

Persistence of Healthcare Acquired Infections in Long-Term Care Facilities

Despite the focus on infection prevention and control (IPC) during the COVID-19 pandemic, healthcare associated infections (HAI) in residential aged care facilities (RACF) are increasing. Residents of RACF are particularly vulnerable to HAI because many have risk factors that increase their risk of acquiring an infection, such as age >65 years, underlying diseases/chronic conditions, impaired mental status or presence of indwelling devices.

HAI prevention in RACF is crucial for the safety of residents. Developing an IPC committee that tracks the facility's progress regarding HAIs, antimicrobial stewardship, and action plans is a first step to ensure that HAIs are being monitored and treated appropriately. It is also important to track, analyse and share HAI investigations and data with frontline staff and key stakeholders. RACF need to:

- Verify that current policies and procedures align with evidence based guidelines.
- Analyse current workflows to identify latent and active failures (e.g. lack of accessible ABHR for hand hygiene) that may increase risk of infections in residents.
- Create action plans to address identified causes of infection.
- Empower residents and their families to assist with HAI prevention and mitigation from hand hygiene, care of indwelling devices, to vaccination.
- Provide staff education on and access to appropriate PPE, hand hygiene facilities and disinfectants, which is crucial.
- Recognise that some residents and staff have a different first language than English, and determine how to provide education and information to these people.

Read the full article [HERE](#)

WHAT'S NEW

Australian Commission on Safety and Quality in Healthcare Strategic Plan 2025 – 2030



The Australian Commission on Safety and Quality in Healthcare has released its Strategic Plan 2025 – 2030 with 4 strategic priorities:

- **High-quality care** in an evolving environment, including the impact of artificial intelligence, new models of care and climate change.
- **Strong outcome-focussed clinical governance**, increasingly shaped by data and evidence about outcomes.
- **Empowered patients, carers and communities** at every level of healthcare design and delivery.
- **An improvement-driven workforce culture** which makes better healthcare everyone's responsibilities and fosters accountability, continuous learning, cultural safety and a readiness to improve.

Read the Strategic Plan [HERE](#)



Australian Government

Department of Health, Disability and Ageing

Amendments to Medicare Benefits Schedule (MBS) for Urine Testing in Asymptomatic Patients

From 1 July 2025, Medicare Benefits Schedule (MBS) item for urine testing (69333) will be amended to reduce clinically unnecessary testing and improve patient outcomes by requiring that asymptomatic urine testing be only performed when clinically indicated.

This amendment stipulates that urine testing and examination (including serial examinations) are only required when symptoms of a urinary tract infection or kidney disease are present. Practitioners are encouraged to consult the most up-to-date guidelines on indications of urinary tract infection or kidney disease. At the time of publishing, this may include not only pain with urination and frequency of urination, but also systemic presentations such as suspected sepsis, delirium (defined as a sudden, temporary change in mental status developing quickly over hours or day with symptoms that fluctuate throughout the day) or fever of unknown origin.

Exception to this amendment is made for specified patient groups who may be asymptomatic including those who are:

- Pregnant
- Less than 16 years of age
- Recipients of renal transplants
- Suffering from recurrent urinary tract infections
- Being investigated or monitored for kidney disease
- Undergoing urinary tract instrumentation, urological procedures, or transurethral resection of the prostate.

Practitioners will be able to request Medicare funded testing for urine examination only when local or systemic signs and symptoms of a urinary tract infection or kidney disease are present. Exceptions to this amendment are made for specified patient groups who may be asymptomatic. This means clinicians can continue to request clinically relevant testing for symptomatic and asymptomatic patients. **However non-guideline supported testing, such as the routine testing of asymptomatic aged care patients, will no longer be Medicare funded.**

This change will assist aged care facilities to improve antimicrobial stewardship by reducing treatment of asymptomatic bacteriuria.

Read the MBS amendment [HERE](#)



Ageing
Australia

National Conference 2025

30 September – 2 October 2025

Gold Coast Convention and Exhibition Centre, Queensland

Meeting the Moment. Shaping the Future.



INFECTION PREVENTION AND CONTROL WEEK 19-25 OCTOBER



International Infection Prevention Week – October 19 to 25

IPC Week is held in the third week of October each year. This year it will be celebrated from 19 – 25 October with the theme “IPC Champions: Leading the Way to a Safer Healthcare”.

We will have more information and IPC resources coming soon!

2025 National Antimicrobial Prescribing Survey (NAPS) Auditing Periods

The NAPS rebuild project is progressing and the aim is to launch the new NAPS platform mid-year. The audit periods for 2025 are scheduled as in above picture.

Module	2025 Auditing Periods
 HOSPITAL NAPS National Antimicrobial Prescribing Survey	January 14 th to December 31 st
 SURGICAL NAPS National Antimicrobial Prescribing Survey	January 14 th to December 31 st
 AGED CARE NAPS National Antimicrobial Prescribing Survey	June 1 st to December 31 st
 ANTIFUNGAL NAPS National Antimicrobial Prescribing Survey	National Benchmarking methodology TBC* June 1 st to December 31 st

ACIPC International Conference 16-19 November 2025

Important Dates:

- **Registration Open:** Now open - [Click here to register](#)
- **Early Registration Discount Closes:** 1 October 2025



World AMR Awareness Week- 18 to 24 November



World AMR Awareness Week (WAAW) is a global campaign that is celebrated annually to improve awareness and understanding of AMR and encourage best practices among the public, One Health stakeholders and policymakers, who all play a critical role in reducing the further emergence and spread of AMR.

Find out more [HERE](#)

Following the theme of World Sepsis Day, have a try at the **Aseptic Technique Crossword** below. Answers will be given in the next newsletter.

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CLUES

ACROSS	DOWN
<p>1. Type of AT used for simple, quick procedures.</p> <p>5. An AT occurrence.</p> <p>7. Time frame for standard AT.</p> <p>9. Packaging not damaged or compromised.</p> <p>11. Same practices applied.</p> <p>13. Personal Protective Equipment (abbreviation).</p> <p>15. Everything.</p> <p>16. AT is always required for these types of procedures.</p>	<p>2. Free from contamination with microorganisms.</p> <p>3. Framework that aseptic practice is based on.</p> <p>4. All clinicians should be _____ in AT</p> <p>6. Way of performing AT.</p> <p>8. Only sterile items may come into contact with this type of aseptic field.</p> <p>10. A designated aseptic working area.</p> <p>12. A component of PPE.</p> <p>14. Healthcare Associated Infection (abbreviation)</p>

CONTACT

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