AGED CARE AND DISABILITY SERVICES

Message from Our Team

Dear Colleagues,

Welcome to the summer edition of our newsletter. We hope you are rested and ready to face the challenges that 2026 is sure to bring, not least the extended heatwaves and/or flooding many parts of Australia have been experiencing. Both these extreme weather events can bring their own unique challenges to infection prevention and control (IPC).

This is again a bumper issue with a selection of articles addressing a wide range of IPC topics. One theme many of you will relate to looks at how aged care staff perceive their role in IPC, and identifying some of the barriers and enhancers to implementing good IPC in aged care. These articles may help you identify the barriers and enablers in your own facility.

The new Aged Care Act 2024 commenced on 1 November 2025, representing a fundamental shift to a rights-based system of care and including compliance against the updated quality standards. We know you have all been busy preparing to transition to the new standards. The Australasian College for Infection Prevention and Control (ACIPC) has updated the Foundations of IPC course and the Aged Care IPC Short Course to align directly with the requirements of the new Aged Care Act and the Strengthened Aged Care Quality Standards to assist IPC Clinical Leads understanding their roles and the transition.

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 cool.

In This Issue We Have

IMMUNISATION UPDATE

Updated advice for measles vaccination

The Australian Technical Advisory Group on Immunisation (ATAGI) recently updated advice to recommend that infants aged 6 to 11 months should receive an additional dose of a measles-containing vaccine (MMR vaccine) when travelling overseas.

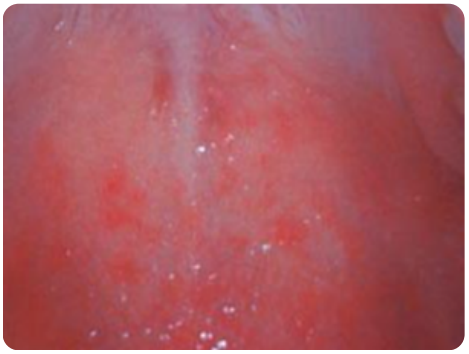
The MMR vaccine is highly effective - two doses provide 99% protection against illness and serious health complications. Most Australians receive these two doses as part of the National Immunisation Program (NIP) Schedule at 12 and 18 months of age.

Where an infant aged 6 to 11 months receives an MMR dose before travelling overseas, the dose needs to be repeated. This means that these infants need 2 further doses of measles-containing vaccine. They should receive the next dose of MMR vaccine at 12 months of age or 4 weeks after the 1st dose, whichever is later. They should receive their final dose of measles-containing vaccine as MMRV vaccine at 18 months of age as routinely recommended. It is not necessary to repeat an early dose if it was given at greater than 11 months but before 12 months of age.

Typical measles skin rash



Koplik Spots



(Photo's from US Centre for Disease Control (CDC))

Read the Measles Vaccination Advice HERE

Recent CDC publication on vaccines and autism

Recently published information from the US Centre for Disease Control (CDC) contradicts established evidence and widely accepted scientific understanding that vaccines do not cause autism spectrum disorder.

The Royal Australian College of General Practitioners (RACGP), Victorian Healthcare Associated Infection Surveillance System (VICNESS) and Australasian College for Infection Prevention and Control (ACIPC) upholds the evidence-based practice and long-standing evidence supporting vaccine safety.

It is important that all healthcare professionals provide clear, accurate and credible guidance to uphold public confidence in vaccination programs.

Full details of all vaccines available in Australia are available in the Australian Technical Advisory Group on Immunisation (ATAGI) Australian Immunisation Handbook. The guidance is based on the best scientific evidence available, from published and unpublished literature. For each vaccine preventable disease, the nature of the disease, clinical features and epidemiology are discussed along with vaccine recommendation, doses and administration, contraindications and precautions, and adverse events.

Access the Australian Immunisation Handbook HERE.

See the Australian National Immunisation Program Schedule HERE

Pharmacists can support your aged care vaccination program.

Community pharmacists can:

- immunise residents with vaccines on the National Immunisation Schedule
- provide COVID-19 vaccinations
- help with vaccination clinics.

Aged Care Onsite Pharmacists and pharmacists who offer Quality Use of Medicine services can help providers develop a system to track vaccinations.

Read the full story here: Vaccination planning using the Australian Immunisation Register and support from pharmacists


(Photo from US Centre for Disease Control (CDC))

Spotlight Organism

Methicillin Resistant Staphylococcus aureus (MRSA)

What?

Staphylococcus aureus (S. aureus) are bacteria commonly found on the skin and in the noses of healthy people. It occurs as either Methicillin-sensitive *S. aureus* (MSSA) or Methicillin-resistant *S. aureus* (MRSA). MRSA are *S. aureus* that have developed resistance to the beta-lactam class of antibiotics e.g., penicillins, cephalosporins and carbapenems. While MRSA is not more pathogenic or virulent than strains of MSSA, it does pose greater treatment challenges due to the reduced availability of effective antibiotics and is associated with increased morbidity and mortality.

Colonisation vs Infection

Colonisation refers to detection of a microorganism from a site which shows no clinical sign of physical infection.

Infection refers to invasion of the host with the production of inflammation and/or bacteraemia at the site of infection.

Colonisation with MRSA usually does not cause any harm, however MRSA can cause serious infections when it gets into wounds and/or the bloodstream.

Who is at risk of infection?

Anyone can become infected with a MRSA infection, but people who have an increased risk of getting a MRSA infection are those who:

- have other chronic health conditions, including diabetes, dermatitis, chronic wounds or whose immune systems are immature or weakened
- have been treated with antibiotics, and have been in a healthcare facility or a nursing home
- regularly have medical equipment entering their body, such as catheters and feeding tubes
- spend time in crowded living conditions or in environments where frequent direct physical (skin to skin) contact may occur.

In other words, your average resident in an aged care facility.

How is MRSA spread? By contact transmission, either directly by the hands of healthcare workers or indirectly from contact with contaminated surfaces and equipment.

How Can The Spread of MRSA Be Prevented? Effective hand hygiene is the single most effective action to reduce transmission of MRSA. Keeping infected wounds covered and not sharing towels or clothes with other people also minimizes the risk.

How Is MRSA Treated?

If a person is colonised with MRSA, treatment is often not required unless the colonised person requires surgery, then treatment with a medicated body wash and nasal ointment is often prescribed to reduce the amount of MRSA on the skin. If you have a MRSA infection, then a course of antibiotics that is effective against MRSA may be prescribed.

Pathology Results: When interpreting pathology results from wound swabs – microscopy, culture and sensitivity (MC&S), it is important to accurately read the report to determine if the organism is MSSA or MRSA, and if it is susceptible to the prescribed antibiotics.

For more information see MRSA Healthcare Associated Infections – Information for Patients

INTERESTING ITEMS

A priority framework for the development of a health care-associated infection surveillance program in Australian residential aged care homes: Analysis of a Delphi technique

In Australia there is currently no national residential aged care healthcare associated infection (HAI) surveillance program, and until recently there has been no agreed scope.

The National Infection Surveillance Program for Aged Care (NISPAC) Advisory Group conducted three sequential anonymous and independent surveys by 25 to 40 subject matter experts. Participants rated the importance and feasibility of including potential program elements in a national RACH HAI surveillance program using Likert scales. Program elements were classified "priority 1" (if there was consensual agreement for importance and feasibility), 2, 3, or nonpriority.

Of 58 potential program elements, 26 were classified as priority 1; this included program elements focused on infection surveillance (5), infection detection criteria (1), organism surveillance (8), isolate monitoring methods (1), vaccination compliance (4), vaccination compliance targets (4), and

antimicrobial appropriateness measures (3). Six, 14, and 12 program elements were classified priority 2, 3, and nonpriority, respectively.

The study results have led to the development of a strategic framework for a national RACH HAI surveillance program by determining priorities for inclusion of program elements. This framework has now been used to develop a pilot program for Australian RACHs.

See full details HERE

This analysis is part of NISPAC's three year mission to develop and implement a national Infection Surveillance Program for Aged Care. Once completed, NISPAC will provide a dedicated and secure portal accessible by aged-care staff to enable participation in a national IPC surveillance program that includes quality indicators, benchmark reporting and IPC support resources.

Cracking the Code: Are runny eggs safe in aged care?

Food safety is very important in aged care. Older people are at higher risk of foodborne illnesses (food poisoning) due to changes their bodies go through with age. Salmonella bacteria can be found in raw or undercooked eggs, so they can be a serious health threat to older people. Although runny eggs are a high-risk food, many older people enjoy – and ask for – soft-boiled, poached, or sunny-side-up eggs.

Respecting food preferences isn't only about enjoyment. It's about identity, independence and culture. Food isn't just fuel in aged care. It's one of the last ways older people can exercise choice. If they want runny eggs, providers owe it to them to find a safe way to support their choice.



Under the food safety standards, businesses that serve food to vulnerable people, such as residential aged care services, must have a food safety program, which must be regularly monitored and reviewed as directed, and it should describe the steps they take to manage risks and make sure food provided is safe.

Residential aged care providers must balance the health risks with older people's right to choice and they must document the decisions they make. Risk doesn't mean restriction. It means managing food safety with dignity and respect.

Read the full article HERE

Following on from the above article - What is Salmonella bacteria?

Salmonellosis (or Salmonella) is a disease caused by infection with bacteria called Salmonella. In Australia, most Salmonella infections occur after eating contaminated food or sometimes after contact with another person with the infection.

Symptoms of Salmonella include headache, fever, stomach cramps, diarrhea, nausea and vomiting.

Incubation Period and Duration:

Symptoms usually start 6-72 hours after exposure to the bacteria and usually last for 4-7 days. Symptoms can sometimes last a lot longer.

Transmission of Salmonella: Salmonella is usually spread to humans by eating undercooked food made from infected animals (for example, undercooked meat, poultry and foods from animals such as eggs). It can also be spread by:

- Cross-contamination –this is when the Salmonella from contaminated food is spread to other food. For example, if a knife is used to cut food contaminated with Salmonella and is then used to cut food that will not be cooked further, the Salmonella will grow in the new food
- Person-to-person – if hands are not washed properly, particularly when preparing food. It can also be spread from animals to humans.

Prevention of Salmonella:

***Cooking*:** Cooking food well kills Salmonella. Avoid raw or undercooked meat, poultry, or eggs. Poultry and meat - such as hamburgers, sausages, and rolled roasts - should be cooked until you can see no pink in the middle.

Hand hygiene: Always clean your hands thoroughly after going to the toilet, changing nappies, touching animals, before and after handling food and before eating. It is important to particularly clean under the fingernails and between fingers.

Infected food handlers can spread the bacteria easily. They should not handle or serve food until 48 hours after the diarrhoea has stopped.

***Temperature control*:** Keeping food out of the 5-60°C danger zone.

***Food handling and contamination*:** Use good food handling practices:

- store raw foods (such as meat) in sealed containers in the bottom of the fridge or freezer to stop any fluid dripping or spilling onto other ready-to-eat food.
- Cover all foods in the refrigerator and freezer to protect them from contamination
- Use different chopping boards, trays, utensils and plates when preparing raw foods and ready-to-eat food. If you have only one chopping board, wash it well in hot, soapy water before reuse
- Thoroughly wash all dirt off any raw vegetables and fruits before preparing and eating them
- Dry dishes with a different cloth from that used for wiping hands or bench tops and wash dish cloths regularly.

Nursing home visitor policy and COVID-19 infection rates

This study looked at RACH that allowed visitors during the COVID-19 pandemic, and the association between visitors and COVID-19 infection rates among residents. A cohort of 677 RACH that allowed external visitors was assessed between 29 October 2020 and 3 January 2021. COVID-19 resident infection rates, community infection rates and facility characteristics were assessed.

Of the 677 homes, the number allowing visitors during any given week ranged from 226 to 327. The results found that allowing visitors in the context of adequate infection prevention measures was safe, even during high community transmission and before vaccine rollouts.

Read the full article HERE

IN FOCUS

A qualitative study of health care professionals' attitudes and practices of mobile equipment cleaning

Skilled nursing facilities report a high prevalence of multidrug-resistant organisms (MDROs) among their vulnerable patient population. Skilled nursing facilities provide care and rehabilitation services for patients with intermediate care needs where hospitalization is no longer required but greater than would be available if discharged to their residence.

MDROs are also common in long-term care settings, with at least half of nursing home residents colonized with at least 1 MDRO and three-quarters of resident rooms being contaminated. While research has identified fomite-mediated transmission such as surfaces and health care professional (HCP) hands and clothing, emerging work on outbreaks has focused on the role of mobile medical equipment and associated cleaning procedures. This study sought to better characterize HCP attitudes toward cleaning and MDRO transmission, as well as describe cleaning practices for mobile equipment.

Fifteen focus groups were conducted at 3 skilled nursing facilities ($n \geq 4$ focus groups per site) with HCP likely to be tasked with cleaning mobile equipment (i.e.,nurses, certified nursing assistants, and environmental service workers).

Participants at all 3 sites described suboptimal cleaning practices of mobile equipment. Barriers to MDRO infection prevention and control practices included time pressure, knowledge gaps, and cost (material and staff).

Recommendations from numerous key bodies include cleaning and decontamination of equipment after each patient use, because effective cleaning and disinfection of mobile medical equipment should decrease health care-associated infections. However, routine cleaning of medical equipment is frequently inadequate in health care settings. Numerous interventions have been proposed to mitigate insufficient cleaning; however, their evaluations demonstrated mixed or limited decreases in health care-associated infections.

The objective of this study was to better understand HCP attitudes, self-reported practices, and challenges to mobile equipment cleaning in skilled nursing, long-term acute care, and rehabilitation hospital settings.

Understaffing created the major challenge to cleaning shared equipment at 2 of the 3 sites. The number and type of mobile equipment used in skilled nursing facilities, frequency of mobile equipment use, attitudes and policies related to cleaning between uses, availability of guidance toward effective cleaning practices, allocation of responsibility for cleaning of mobile equipment, and availability of resources (time, material, and staff) required for effective mobile equipment cleaning may all contribute to gaps in cleaning practice.

Finally, the focus groups revealed consistent ambiguity between HCP roles on responsibility for cleaning of medical devices. This was particularly evident, but not limited to the cleaning of mobile devices such as glucometers and vital signs carts.

Read the full article HERE

Wiping cloth material choice significantly impacts the bactericidal efficacy of select disinfectant chemistries in environmental surface decontamination

Manual surface wiping is a primary method in preventing hospital-acquired infections. Wiping varies significantly in its ability to eliminate bacteria and prevent cross-contamination.

In this study, four liquid-based cleaning and disinfecting formulations (hydrogen peroxide, ethoxylated alcohol, quaternary ammonium compounds (Quat and Quat2), and a water-based control) were evaluated for their bactericidal efficacy in combination with 3 different wiping materials: microfiber, polypropylene, and cotton. Each chemistry and wipe combination was evaluated for its ability to reduce microbial contamination on a hard, nonporous surface measuring 1metre. The bactericidal efficacy of each pairing was tested against 2 bacterial strains, *Staphylococcus aureus* (ATCC 6538) and *Pseudomonas aeruginosa* (ATCC 15442).

Wiping material choice was found to impact the bactericidal efficacy of liquid chemistries in surface decontamination, underscoring the need to select effective material-chemistry combinations to reduce viable bacteria and limit cross-contamination.

The results showed that:

- wipes containing hydrogen peroxide exhibited the highest bactericidal efficacy among tested formulations, transferring the least bacteria across test surfaces;
- Polypropylene wipes consistently outperformed cotton, removing a greater proportion of bacteria from the inoculation site and transferring fewer to secondary areas; and
- Wipes impregnated with ethoxylated alcohol, Quat, and Quat2 retained viable bacteria on the wipe, contributing to increased cross-contamination to other surfaces.

Read the full article HERE

The hidden variable in hand hygiene: Why dose size, standards and technology matter

Hand hygiene remains the cornerstone of infection prevention and control (IPC) in healthcare, but generally the focus is on *when* to clean hands, not *how much* product is needed.

The “chain of transmission” reminds us how quickly pathogens move from reservoirs to susceptible hosts. A health care worker who skips proper sanitization—or uses too little sanitizer—can inadvertently become a link in this chain. This chain includes the infectious agent, reservoir, portal of exit, mode of transmission, portal of entry, and susceptible host. In clinical environments, health care workers may inadvertently become a link in this chain, especially during patient care activities such as physical examinations or handling of shared equipment if proper hand hygiene is not maintained

Hand sanitisers are fast, effective and convenient. They typically kill a broad range of pathogens in 20-30 seconds. However, using too little product, or less than 1.5 mL, can leave approximately 5% to 10% of the hand surface untreated, allowing germs to potentially survive and spread through the hands of health care personnel in contact with patients, equipment, or the environment, and creating a false sense of cleanliness.

The product must cover all surfaces of the hands and remain wet long enough to kill organisms. The World Health Organisation (WHO) recommends that sanitiser remains wet on hands for about 20 seconds. Too small a dose dries too quickly, too large a dose may take 30+ seconds to dry and discourage staff from using it.

Every pump of sanitizer is an opportunity to break the chain of transmission. The key insight is that it is not enough for health care workers to merely comply with the *when*. The *how much* ensures that adherence is protective.

Read the full article HERE

Writing an effective water management program for long term care facilities

All healthcare facilities in WA and Queensland (including residential aged care facilities) are required to have a water management plan to reduce the risk for Legionnaires’ disease associated with a building water system and devices. See WA Health guidelines and Queensland Health - Legionella. South Australian facilities are required to manage legionella risks and are strongly recommended to have a formal WRMP in place. This water management plan should identify areas or devices in the building where Legionella might grow or spread to people so that the risk can be reduced.

Legionnaires’ disease (LD) remains a deadly but preventable threat in health care, especially in long-term care. It is a potentially life-threatening pneumonia caused by the *Legionella pneumophila* bacteria.

LD is spread by inhalation of aerosolized droplets of water that are contaminated by *L. pneumophilia.* Sources include air conditioning systems, showers, nebulizers, hot tubs, and decorative water features. Infection requires the inhalation or aspiration of these droplets into the lungs.

People at increased risk of infection are adults over 50 years, current or former smokers, people with a weakened immune system, diabetics, and people with chronic lung or kidney diseases, characteristics that describe most residents of long-term care facilities.

Components of an effective Water Risk Management Plan (WRMP) include:

- A team, including infection prevention and control (IPC) representation to develop, manage and monitor the WRMP;
- A risk assessment of the facility's entire water system to identify water temperatures and places where legionella can grow;
- Control Measures to reduce the risk of legionella growth, including flushing, disinfection, cleaning, and heating. This step also includes identifying where control measures are applied and the relevant control limits;
- Monitoring of control measures and testing results;
- Training of those staff/people implementing the control measures; and
- Verification to ensure the WRMP is working as intended.

There are numerous companies that can assist facilities to develop a thorough WRMP. The *enHealth Guidance – Guidelines for Legionella Control* from the Environmental Health Standing Committee (enHealth) provides clear information for facilities wishing to develop their own WRMP, or for use as a tool to improve understanding of legionella risk management, and WRMPs.

FEATURE ARTICLE

Monitoring urinary tract infections in residents of Australian aged care homes: Clinical and microbiological characteristics identified through a pilot surveillance program

Urinary tract infections (UTIs) are a significant burden among residents of aged care homes (ACHs). The objective of this study was to describe 'UTI event' data reported by Australian ACHs, and to compare clinical and microbiological characteristics with surveillance and clinical case-definitions for UTI.

Methods

Australian ACHs involved in the pilot National Infection Surveillance Program for Aged Care (NISPAC) were offered participation in a pilot study of UTI surveillance. NISPAC study participants, involving 64 ACHs, were invited to voluntarily take part in NISPAC UTI surveillance. ACH staff performing surveillance were employed as IPC leads in the ACHs and were nurses who had undertaken foundational training in IPC. Standardised data collection tools captured resident-days, catheter-days, clinical and microbiological event data. Reported UTI events were evaluated to determine whether criteria for accepted surveillance (Stone/revised McGeer) or clinical (Australian Therapeutic Guideline) UTI case-definitions were met.

Results

136,333 resident days and 4,659 resident catheter-days were submitted by 25 ACHs from five Australian jurisdictions with 60% from metropolitan areas and 64% from not-for-profit ACHs. In total, 172 UTI events with at least one sign or symptom were reported (150 in non-catheterised residents and 21 in catheterised residents), with the most commonly reported being 'new onset confusion or functional decline' (116/172, 67.4%). Almost half (71/150, 47.3%) non-catheterised resident events did not meet either Stone or Therapeutic Guidelines modified case definitions for UTI. Over half (45/89, 50.6%) of urine cultures from non-catheterised residents met laboratory criteria for UTI but lacked sufficient signs or symptoms to fulfil UTI case definitions.

Conclusion

Nearly half of reported UTI events did not meet surveillance or clinical case-definitions. The most frequent signs and symptoms reported in non-catheterised residents were new onset confusion or functional decline (68%), new or increase in urinary frequency (40.7%), and dysuria (26%). New onset confusion or functional decline was also the most commonly reported clinical feature in catheterised residents (66.7%), followed by haematuria (23.8%), and costovertebral pain or tenderness (19.0%).

Of 150 non-catheterised residents with a reported UTI event, 27.3 % met modified Stone/McGeer case definitions for confirmed UTI and 50.0 % met the modified Therapeutic Guidelines case definitions for clinically suspected UTI. Almost half (47.3 %) of reported events did not meet either Stone or Therapeutic Guidelines criteria for UTI. Four events met Stone criteria but not Therapeutic Guidelines criteria.

In Australia, performing urine cultures when UTI is clinically suspected and avoiding testing when there are no signs or symptoms of UTI is encouraged as best practice in older people, including those living in ACHs, 50.6% of urine samples in this study were from residents that did not have sufficient signs and symptoms of suspected UTI.

The study corroborates research suggesting that common clinical scenarios where antibiotics are inappropriately prescribed are triggered by response to non-specific signs and symptoms or a positive urine test (e.g. urine dipstick) in the absence of symptoms related to the urinary tract.



This highlights the need to support initiatives to improve clinician recognition of UTI, recognise asymptomatic bacteriuria and understand the limitations of relying on urine culture alone to confirm UTI. Surveillance of UTI events has an important place in measuring change related to quality improvement.

Read the full article HERE

LITERATURE

Staff perceptions of their roles in infection prevention and control in residential aged care homes: A qualitative study

Residents of residential aged care homes (RACH) are particularly vulnerable to infections. Even the most well-designed policies and guidelines may fail to achieve effective infection prevention and control (IPC) practices with staff engagement. The researchers aimed to examine staff perceptions of their role in IPC in RACH.

IPC programs in RACH are essential to maintaining a safe and healthy environment, and provide a comprehensive framework to prevent and control infections. In this study, 21 direct care and support staff were interviewed across 2 RACH in Melbourne.

Both direct care and support staff perceived their primary role in IPC as providing both physical safety and emotional support to older people. While they recognized the importance of routine and outbreak-related IPC practices, they identified key barriers such as older people's cognitive impairment, home-like environments, and staffing challenges. Most participants felt supported by organizational training but emphasized the need for ongoing IPC education regardless of role.

Staff perceptions of their roles significantly influence their adherence to IPC practices and guidelines. While all RACH staff are expected to contribute to standard IPC practices, much of the existing literature has primarily focused on the perspectives and practices of direct care staff. IPC Leads in RACHs in Australia expressed frustration with unclear role definitions, heavy workloads, and limited resources, although they emphasized the value of supportive leadership and adaptable strategies in managing these issues.

Despite the recognition of IPC roles within RACHs, structural support and staff expertise remain inconsistent, affecting the overall effectiveness of IPC efforts. And a significant gap remains in understanding how nonclinical staff such as cleaners, security officers, and kitchen and catering staff engage with, and influence, IPC practices in RACH settings.

Read the full article HERE

Identifying barriers and enablers to effective infection prevention and control in residential aged care: A qualitative study using the Theoretical Domains Framework

Infection prevention and control (IPC) practices are crucial in residential aged care homes (RACHs), yet gaps between evidence-based recommendations and what is done in practice (called evidence-practice gaps) continue. There are existing evidence-based published recommendations for IPC practices in RACHs, however, IPC practices are implemented variably with public concerns raised about standards of basic infection control and hygiene practices. Understanding barriers and enablers to implementing evidence-based IPC is essential for improvement.

This study aims to identify barriers and enablers to RACH staff performing evidence-based IPC practices. Semi-structured interviews were conducted with 28 staff (including nurses, personal carers and lifestyle staff) from 9 RACHs in Victoria, Australia. Interviews explored 7 prioritized IPC evidence-practice gaps.

Key enablers identified included:

- knowledge of IPC importance,
- access to equipment and resources,
- skills and experience,
- self-confidence,
- visual cues, and
- beliefs about protecting self and others.

Main barriers identified were related to:

- environmental context and resources, including limited access to hand hygiene products and personal protective equipment, and
- Social influences and competing priorities.

Read the full article HERE

Antibiotic use in nursing homes: A qualitative study on knowledge and attitudes among assistant nurses, nurses and general practitioners

Whilst antimicrobial stewardship (AMS) programs have been proven effective in hospitals, implementing them in RACH has been challenging and antibiotic resistance in homes is a major problem. This study aimed to provide an overview of assistant nurses, nurses and general practitioner knowledge and attitudes towards antibiotic use with a view to better inform the development of AMS programs in RACH.

Semi-structured individual interviews were conducted with 9 assistant nurses, 15 nurses and 13 general practitioners, using separate interview guides for each category of health professional.

The results found that health professional's attitudes towards antibiotic use was ambivalent. Despite the occurrence of side effects, assistant nurses and nurses indicated that dependant elderly people needed antibiotic prescribing. General practitioners perceived antibiotic use as necessary to prevent rapid deterioration of residents. Assistant nurses and nurses would like to better understand the reasons for antibiotic prescribing.

The authors concluded that the development of AMS interventions that built on the cognitive dissonance and expressed need for training by integrating messages about the risks of overprescribing, and promoting interprofessional decision-making which makes best use of nurses and assistant nurses knowledge of resident conditions, could allow general practitioners to adjust their prescribing and attitudes.

Read more HERE.

A microbiological analysis of shared bathroom facilities

A recent study showed that communal shower surfaces in residential aged care homes can serve as reservoirs for pathogenic bacteria associated with healthcare associated infection.

Sampling identified widespread contamination, with methicillin-resistant *Staphylococcus aureus* (MRSA) & *S. aureus* most frequently detected. Floor drains and shower surfaces had the highest bacterial loads, making them primary contamination hotspots. Enteric bacteria & Pseudomonas species were also common in drains, while Bacillus species appeared on lower-contact surfaces. These findings are concerning given the vulnerability of long-term care populations.

Other studies highlight that toilet plumes from toilet flushing can disseminate microorganisms into the bathroom air & onto surfaces.

Current bathroom management practices in shared living facilities may benefit by improved environmental cleaning & disinfection, and improved staff awareness. Improved bathroom ventilation and drain maintenance have also been identified as key issues

Read the full article HERE

NEWS AND EVENTS

WA Health: Infectious Diseases Health Alerts for clinicians - New online infectious diseases notification form

On 09/09/2025 an online notification form for clinicians to report notifiable diseases and related conditions is available on the WA Health website.

The online notification form aims to reduce administrative burden, streamline workflows, and minimise data processing delays, allowing for a timely public health response.

- The online form replaces the need to fax or mail the completed form. Whilst mail and fax notification is still available, clinicians are encouraged to report online.
- When submitting the form, an option is available to download a copy of the completed form in PDF format for record-keeping purposes.
- The form is hosted on a secure data collection platform that complies with data protection and security protocols.
- Clinicians must continue to notify **urgently** notifiable infectious diseases (only) by **phone** to their local public health unit, or the on-call public health physician via 1800 434 122 if after-hours.

The online form is available at: https://redcap.link/wa-disease-notification-form

ACIPC Foundations of Infection Prevention and Control Course and Aged Care IPC Short Course

The Australasian College for Infection Prevention and Control (ACIPC) has redesigned the Foundations of IPC course and the Aged Care IPC Short Course to align directly with the requirements of the new Aged Care Act and the Strengthened Aged Care Quality Standards.

See full details HERE

Aged Care Glove Use Resources



ACIPC has collaborated with aged care providers to produce a range of resource materials to guide appropriate glove use in aged care. The resources are samples of working documents which are able to be used and altered to meet the needs of individual environments.

They cover four areas:

🧤 gloving for care

🧤 gloving for environmental cleaning

🧤 gloving for laundry practices

🧤 gloving for catering

The resources can be viewed and downloaded HERE

ACIPC Aged Care Community of Practice Webinar Series

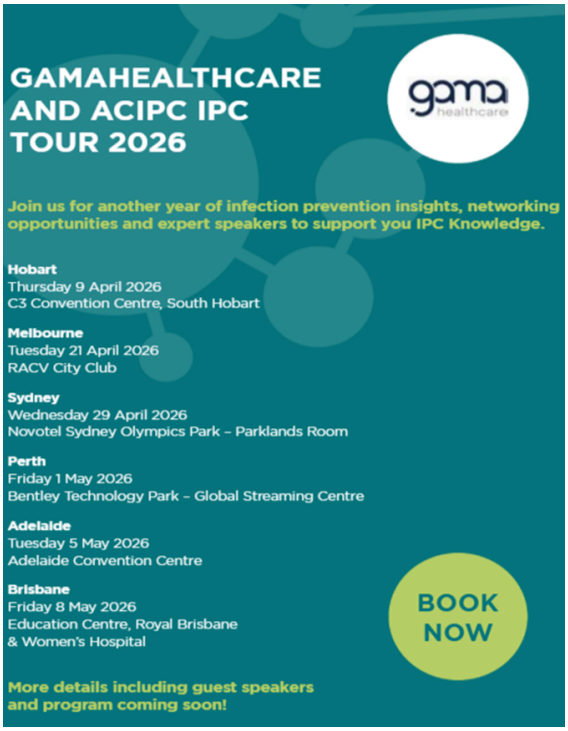
The 2026 webinar series has been announced.

- 18 February 2026: *Understanding asymptomatic bacteriuria Vs UTI in older person*
- 18 March 2026: *Diagnostic stewardship – from swab to requisition*
- 15 April 2026: *Scabies in residential care – identification, management and outbreak control*
- 20 May 2026: *Aged care IPC Governance*
- 17 June 2026: *A feel for ventilation in residential aged care*
- 15 July 2026: *Risk Management - aged care hierarchy of control*
- 19 August 2026: *Vaccination program in aged care*
- 16 September 2026*: Actioning AMS*
- 14 October 2026: *Community care IPC*

These webinars are open to everyone, membership is not required.

View details and register for the aged care webinars HERE





Register [HERE]

ACIPC International Conference 8-11 November 2026



Important Dates:

- **Call for Abstracts** March, 2026
- **Conference Starts** Sunday, 8 November 2026

Conference Closes Wednesday, 11 November 2026

Puzzle – Word Scramble

Stage 1: Unscramble the words below to identify word associated with IPC.

YTIQALU

NLITOSAIO

		3						

WELDGEKON

								7

VOGSEL

			4		

LEVTINONTIA

						9				

TRUPPOS

			1			

SELIGINUDE

			6						

SPICOILE

							8

MICANIROBALTI

							2					

NAHD GYHIEEN

								5			

SPETICA CHENQITUE

						11										

FULENICEN

		10						

Stage 2: Place The Numbered Letters In The Boxes Below To Reveal The Goal Of IPC

1	2	3	4	5	6	7		8	9	10	7		11	9	2	7

CONTACT

For feedback, partnerships, or further information, please feel free to contact us at info@handsoninfectioncontrol.com.au

Hands-On Infection Control

Suite 1, 120-122 Lake Street

Perth Western Australia 6000