INPATIENT AND DAY HOSPITALS

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 has 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 such as evaluation of mobile equipment cleaning, cleaning cloths and disinfectant use, and peripheral intravenous cannulae (PIVC) standards vs practices. Our feature article takes an in depth look at the considerations requiring evaluation when determining if reusable medical devices (RMD) or disposable, single use medical devices are more appropriate for use. Plus there are many items of interest. An article from an IPC Practitioner reflecting on two decades of practice, and the changes she has experienced will bring back memories (fond or otherwise) for those who have been involved in IPC for some time.

Give our word puzzle a try, it is designed to get you thinking about the overall goal of IPC.

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

IMMUNISATION UPDATES

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.

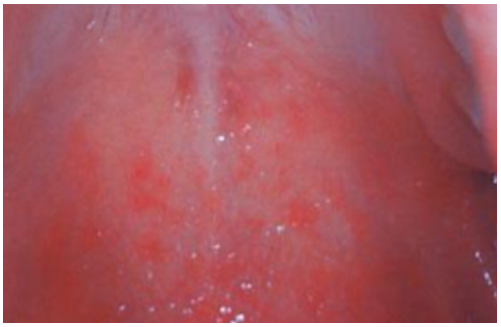
It is not necessary to repeat an early dose if it was given at greater than 11 months but before 12 months of age.

Read the Measles Vaccination Advice HERE

Typical measles skin rash



Koplik Spots



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

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) all uphold 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, precautions, and adverse events.

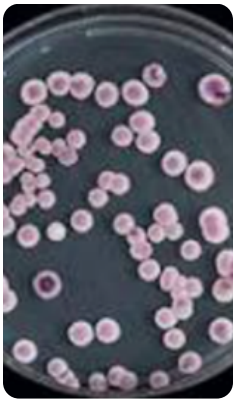
Access the Australian Immunisation Handbook HERE.

See the Australian National Immunisation Program Schedule HERE



Spotlight Organism

Candidozyma auris



Previously known as *Candida auris* or *C. auris*, this is a yeast/fungus in the Candida family that may be multi-resistant and can spread between patients and the environment. To date in Australia, most cases of *C. auris* have had overseas travel history or been admitted to an overseas hospital and received treatment in an overseas healthcare facility. While reports of *C. auris* remain relatively low in Australia, the National Alert System for Critical Antimicrobial Resistance (CARAlert) data shows that the number of reports of *C. auris* isolates has been increasing over the past five years. Countries that are high risk for *C. auris* transmission include South Africa, Pakistan, India, China, and the United Kingdom.

Like other Candida species, it may cause colonisation or invasive infection, with infection being associated with moderate to high mortality (30-60% for *C. auris* sepsis). There are a few features of *C. auris* that differentiate it from most other Candida species such as *C. albicans*. *C. auris*:

- spreads easily between patients in hospitals and residential care facilities;

- may survive in the environment for several weeks and may be resistant to commonly used hospital disinfectants;
- can cause serious infections such as bloodstream and wound infections;
- is hard to identify in the laboratory; and
- may be multidrug resistant and therefore more difficult to treat.

People can be colonised with *C. auris*, carrying the organism on their body without any signs or symptoms. Decolonisation is not recommended. In people who are very ill or have weakened immune systems, it may cause serious infections.

C. auris infections can be treated with antifungal drugs, however, some *C. auris* have become resistant (this means some medications are no longer effective), to the three main types of antifungal drugs, making them more difficult to treat. Signs and symptoms of *C. auris* infection will depend on the site of the infection. The incubation period is unknown, and the infectious period is unknown. People colonised with *C. auris* are considered to be infectious indefinitely.

C. auris is a notifiable disease in many states of Australia (WA, Victoria, NSW, SA). All states are required to screen patients if, in the previous 12 months, they have travelled overseas and received care in any healthcare facility whilst overseas. This includes any type of day visit to dialysis or cancer services, short stay admissions for surgical procedures (such as dental/surgical implants or cosmetic surgery) and any overnight stay in an overseas healthcare facility. If they have received any care overseas within that 12 month period, they should be screened for *C. auris*.

Screening should preferably be undertaken prior to admission. Screening is conducted using a dry swab (can be pre-moistened with sterile water – no transport medium to be used) sampling both axillae, and both sides of the groin. A single swab can be used for all 4 sites. Samples should be collected on 3 consecutive days. If screening cannot be done prior to admission, patients should be cared for in a single room with ensuite under standard and contact precautions until screening results are available. If *C. auris* is being screened for, ensure it is clearly noted on the request form and liaise with the laboratory to ensure appropriate testing is performed.

For further information see below:

WA Health: Screening and management of multi-resistant organisms in healthcare facilities

SA Health: Candida auris – including symptoms, treatment and prevention

NSW CEC: Information for Clinicians - Candida auris (C. auris)

Victoria Department of Health: Candida auris (C. auris)

IN THE LITERATURE

Management, Use and Documentation of Off-Label Antimicrobials in the Operating Theatre: A Survey of Australian Hospital Pharmacists

Overuse and inappropriate use of antimicrobials is a substantial driver of suboptimal patient care and outcomes, including antimicrobial resistance (AMR). With the exception of some ophthalmic surgical procedures, routine use of topical antimicrobials on surgical sites is not recommended as it contributes to the emergence of AMR. This document is a research paper investigating the use and documentation of off-label antimicrobials in Australian operating theatres, focusing on their implications for patient safety and antimicrobial stewardship.

Management and Use of Off-Label Antimicrobials

The study investigates the management, use and documentation of off-label antimicrobials in Australian operating theatres, highlighting significant variations and safety concerns.

- A cross-sectional survey of 61 Australian hospital pharmacists was conducted
- 83% reported ceftriaxone stocked in operating theatres (OT), with 70% stocking IV amoxicillin-clavulanate and 62% stocking piperacillin-tazobactam
- Vancomycin (34%), rifampicin (18%), and gentamicin (16%) were the most commonly used for wound irrigation
- 51% of participants observed vancomycin powder applied directly to surgical sites
- Thematic analysis revealed three main themes: surgical staff work-arounds, risks to patient safety, and unclear pharmacist roles in OT.

Documentation Practices in Operating Theatres

The documentation of off-label antimicrobial use in operating theatres is inconsistent and often lacking.

- 25% of respondents indicated that antimicrobial washes or irrigations are not usually documented
- 23% believed that direct application of powders or pastes to surgical sites is rarely documented
- The operation note or anaesthetic record was the most common documentation location, with only 20% indicating that washes or irrigations would be on the medication chart
- Participants noted that documentation practices are extremely variable and often poorly executed.

Survey Findings on Antimicrobial Stewardship

The survey revealed significant gaps in antimicrobial stewardship practices in operating theatres.

- 33.3% of participants indicated that no approval from an Infectious Disease Specialist is required for restricted antimicrobials
- 53.3% stated that approval is required for some or all restricted antimicrobials
- There is wide variation in the types of restricted antimicrobials stocked in OT across hospitals
- The study highlights the need for improved governance and oversight of antimicrobial use in surgical settings.

Themes from Pharmacists' Observations

Pharmacists identified key themes regarding the use of off-label antimicrobials in the operating theatre.

- Surgical staff often bypass established policies due to time pressures, leading to work-arounds
- Concerns were raised about patient safety due to inadequate documentation and lack of evidence for some practices
- Pharmacists feel isolated and lack support in the operating theatre, which undermines their role in ensuring safe medication use.

Implications for Patient Safety and Quality Improvement

The findings underscore the need for enhanced patient safety measures and quality improvement initiatives.

- Poor documentation compromises patient safety and makes it difficult to evaluate clinical outcomes
- The study suggests that current practices may not align with established antimicrobial stewardship guidelines
- There is a call for better integration of pharmacists in the operating theatre to improve medication management and documentation practices.

Antimicrobial Use and Resistance in Surgery

Sub-therapeutic concentrations of antimicrobials during surgical procedures may lead to treatment failures and increased resistance.

- Sub-therapeutic concentrations can select for resistant organism
- Insufficient contact duration between antimicrobials and pathogens may hinder effectiveness
- Lack of studies on post-surgery antimicrobial resistance following topical prophylaxis.

Common Topical Antimicrobials in Surgery

Vancomycin and rifampicin are frequently used as topical antimicrobials in surgical settings.

- Most common antimicrobials reported: vancomycin and rifampicin
- Systemic adverse effects from topical applications are often underreported
- Local toxicity from vancomycin can impair surgical wound healing.

Efficacy of Topical Antimicrobials

Studies show mixed results regarding the effectiveness of topical antimicrobials in preventing surgical site infections (SSIs).

- Case control study: No significant difference in infection rates with intra-articular vancomycin ($p = 0.265$)
- Systematic review: Topical vancomycin did not reduce SSI risk in spinal surgery
- Recommendations against topical vancomycin use due to adverse effects without infection rate reduction.

Concerns with Antimicrobial-Soaked Grafts

The practice of using rifampicin-soaked grafts may lead to rapid resistance development.

- Older studies support soaking grafts in rifampicin, but recent research shows resistance development
- Surgeons may compromise rifampicin's effectiveness by using it in this manner.

Variability in Antimicrobial Practices

Antimicrobial use in bone cement during orthopaedic surgery shows significant variability among practitioners.

- Survey of Australian orthopaedic surgeons revealed highly variable antimicrobial agents and doses used
- Many pharmacists are unfamiliar with antimicrobial loading practices in bone cement.

Documentation and Governance Issues

Poor documentation of off-label antimicrobial use presents safety risks and hinders research.

- A quarter of respondents indicated that antimicrobial applications are not usually documented
- Lack of traceability to individual patients raises safety concerns
- Improved governance and documentation systems are needed for off-label antimicrobial use.

Role of Pharmacists in Surgical Settings

Embedding pharmacists in the operating theatre could enhance antimicrobial stewardship and communication.

- Survey respondents highlighted barriers due to policy work-arounds by surgical staff
- Pharmacists could help minimize circumvention of antimicrobial stewardship policies
- Enhanced communication with dispensary staff is essential for quality antimicrobial use.

Limitations of the Survey Findings

The survey's findings may not fully represent antimicrobial use due to pharmacists' limited roles in some hospitals.

- The survey targeted pharmacists for their expertise, but results reflect participant knowledge only
- Lack of documentation complicates the assessment of off-label use and its impact on surgical outcomes
- Findings may be specific to the Australian context, limiting generalizability.

Conclusion on Antimicrobial Governance

There is a need for improved governance and documentation practices in the operating theatre.

- Antimicrobial use in surgery requires more scrutiny compared to other clinical areas
- Standardized documentation and tracking systems are essential for monitoring antimicrobial use
- Opportunities exist to enhance workflow and minimize inappropriate antimicrobial use in surgical settings.

In conclusion, there is wide variation between hospitals regarding which antimicrobials are kept in OT, with inconsistent compliance to systems restricting use in this setting. Opportunities to improve the use of broad-spectrum antimicrobials include: better utilisation of automated dispensing cabinets to track use and facilitate audits, embedding of pharmacists in OT to improve management, and policies to ensure documentation and patient consent for use outside of evidence based guidelines.

Read the full article HERE

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 healthcare settings. Numerous interventions have been proposed to mitigate insufficient cleaning; however, their evaluations demonstrated mixed or limited decreases in healthcare-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, 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

Disinfectants and application methods

Two recent articles both looking at disinfectants and application methods, but from different perspective have been released recently.

1. 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 1 metre. 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

2. Evaluation of different disinfectant chemistries and application methods on surfaces contaminated with *Staphylococcus aureus*

Transmission of healthcare-acquired infections from pathogens such as *Staphylococcus aureus* is still a concern in hospital environments. Proper cleaning and disinfection application methods are essential to mitigate the spread of pathogens. This study looked to determine if there would be significant differences in hygiene outcomes of the products, application methods, and wiping cloths.

Efficacies of 7 products were compared and tested against *S. aureus* American Type Culture Collection 6538 on a 2-square metre Formica surface.

Four application methods were used with 3 wiping cloths to evaluate differences in hygiene outcomes:

- cloth and bucket;
- pre-wet;
- spray surface and wipe with cloth; and
- spray cloth and wipe surface.

Most antimicrobials reduced the risk of cross-contamination, but hydrogen peroxide-based products were most efficacious against *S. aureus* compared with other products. Spray surface and wipe with cloth was the most effective method. Whilst all cleaning cloths retained viable bacteria after disinfection, microfibre cloth caused the least cross-contamination to disinfected surfaces.

There were significant differences in application methods and wiping cloths used in the study. Regardless of product, application method, and cloth used, there was evidence of cross-contamination to previously sterile surfaces, wiping cloths, and gloves, especially when non-antimicrobials were used.

Read more 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 microorganisms 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.

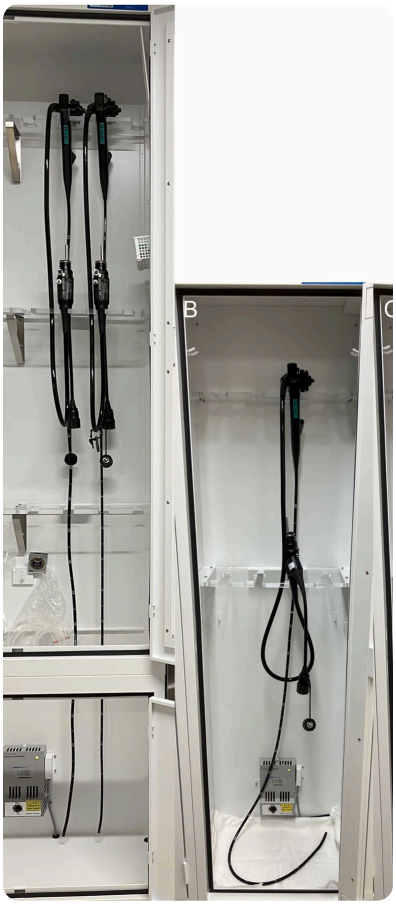
Read the full article HERE

ITEMS OF INTEREST

Storage cabinet design and infection prevention implications for long endoscopes

Adequate drying of endoscope channels following reprocessing is critical to inhibit microbial growth. This study evaluated the residual moisture and bacterial contamination in endoscopes stored using different cabinets and storage methods.

The endoscopes were inoculated with *Pseudomonas aeruginosa*. Endoscopes were stored in 3 different cabinets, 2 with active drying and 1 with passive drying. Full vertical suspension, partial suspension and looped storage methods were used. Residual moisture was measured at 24 and 48 hours, and bacterial cultures were performed.



The results showed:

- In one active drying cabinet (Model TJ-9085) with full vertical suspension, moisture was 23.9 µL at 24 hours and 17.6 µL at 48 hours
- The active drying cabinet equipped with dehumidification (Model TJ-804S) showed inconsistent drying performance, with average moisture volumes ranging from 383.7 µL at 24 hours and 518.7 µL at 48 hours with partial suspension storage, and 289.4 µL at 24 hours and 445.0 at 48 hours with looped storage
- In the active drying cabinet not equipped with a dehumidifier (Model TM-804S), moisture ranged from 343.6 µL at 24 hours and 447.8 µL at 48 hours with partial suspension storage, and 345.7 µL at 24 hours and 278.5 at 48 hours with looped storage
- Bacterial growth varied; minimal growth was found in the TJ-9085 cabinet with full vertical suspension. Both TM-804S and J-804S, using partial suspension or looped storage, showed higher and more variable bacterial growth. The results were not statistically different at 24 hours but were at 48 hours.

The findings demonstrated that the long-endoscope-compatible cabinet allowing full vertical suspension (TJ-908S) achieved the lowest residual moisture and lowest bacterial detection rates compared with other conditions.

Although TJ-804S is equipped with a dehumidification function, its drying performance in this study was inconsistent and, in some cases, inferior to the standard cabinet. This suggests that the presence of a dehumidifier is not sufficient on its own, and that airflow design and endoscope placement reproducibility are likely more influential.

The importance of thorough drying and proper storage in endoscope reprocessing has gained increased attention in recent years. Guidelines such as ANSI/AAMI ST91 emphasize that insufficient drying promotes biofilm formation and increases the risk of microbial contamination. Our findings are consistent with these guidelines and further suggest that structural characteristics of the cabinet---such as height---significantly influence drying efficacy.

Read the full article HERE

Flexibility in action: How infection prevention practitioners thrive in an ever changing landscape

This article is a reflection of an Infection Prevention and Control (IPC) Practitioner over the past two decades, and what has changed.

Name Changes: From early days of "Infection Control Nurse" (implying that only nurses could serve in this role), to Infection Control Practitioner then Infection Preventionists (US). Infection Control departments became Infection Prevention and Control departments. Each name change reflected a shift in responsibilities and a broader understanding of the role within healthcare.

Evolving Qualifications and Reporting Structures: The transition from nurse to practitioner opened the role to people from other disciplines, all contributing a different perspective to the role. Reporting structures changed as IPC came under different departments (e.g. reporting to Chief Nursing Officers, Chief Medical Officers, Quality Directors), also bringing different perspectives depending on the role being reported to.

Technological Transformation: Like many other systems, development from a largely manual process using paper charts, reports and medical records to obtain information has become electronic meaning much easier and more time efficient access to required information. Technology has also impacted how healthcare is delivered, automated surgery and disinfection, new and improved sterilisation machines, and clinical resources accessible on line. All these technology changes has changed how IPC personnel perform their roles in IPC.

A Growing Professional Identity: As IPC grew, it became a recognised clinical specialty with expertise, and associated greater accountability.

Certification and Competency Development: The development of formal competency models and credentialling pathways for the IPC role has further professionalised IPC. IPC now has its own career path and is not just seen as an extension of nursing but includes other disciplines.

Adapting to Emerging Threats: Over the years, IPC practitioners have responded to multiple public health threats, from SARS, H1N1, Ebola, Mpox and COVID-19. Each crisis brought new challenges and required rapid adaptation. Being able to pivot, stay informed and act decisively became essential survival skills.

Reflecting on the past, the author has realised that flexibility isn't optional, it's fundamental in IPC. Technologies shift, reporting structures evolve and new pathogens emerge. What remains consistent is the need for IPC practitioners to adjust quickly and continue to lead with confidence. Flexibility is the bridge between tradition and innovation.

Read the full article HERE

The impact of smartphone-based wound follow-up on surgical site infection detection: A quasi-experimental study

Surgical site infections (SSIs) are common postoperative complications that are frequently missed or diagnosed late due to limited follow-up. This study evaluated a smartphone-based wound follow-up system for detecting SSIs after discharge.

This quasi-experimental study selected 90 patients aged 18 to 70 years undergoing general surgery. The intervention group (n = 30) submitted postoperative wound photos via smartphone for immediate feedback; the control group (n = 60) received routine telephone follow-up at 1 month.

SSIs were detected in 5 patients in the smartphone group and 2 in the control group (*P*=.043). Both groups had primarily moderate infections, with one high-risk infection observed in the smartphone group only. The smartphone intervention was associated with significantly higher odds of SSI detection.

Smartphone-based wound follow-up detected higher SSI rates and may enable earlier diagnosis. However, there were limitations to the study. Given the quasi-experimental design and small sample size, larger randomized multicenter studies are needed to confirm effectiveness and to evaluate longer-term patient outcomes.

Read more details HERE

Study on the air gap effect when closing toilet lid on droplet and pathogens escaping from flushing

Closing the toilet lid before flushing is widely recommended to minimize the dispersal of pathogen-laden aerosols. However, an often-overlooked issue is that aerosols can still escape through the air gap between the bowl and seat even when the lid is closed.

This study was a pilot investigation to assess how the gap height and lid influenced droplet and bioaerosol escape in a seated toilet. Three organisms were studied: *Escherichia coli* and two viruses.

The study found that 92% of droplets generated by flushing were smaller than 1.0 μm, and the viruses escaped more readily through the gap than the *E. coli*. Bioaerosol escaping from the toilet during flushing increased with gap height. When the gap height was 6 mm, escape ratios were 24% for *E. coli and* 49% and 57% for the two viruses.

In summary, whilst lid closure effectively limits the exposure of bioaerosols, the protection afforded by lid closure diminishes as the gap increases.

Read more details HERE

FEATURE ARTICLE

Considerations for switching to disposable equipment

Healthcare organisations are continually balancing patient safety, ensuring infection prevention and control (IPC) remains a top priority, with growing awareness of the environmental impact of healthcare operations. Shifting to disposable equipment is increasingly considered, however it is essential to consider not only the IPC benefits, but the broader logistical, financial and environmental (sustainability_ considerations. A balanced evaluation of all these factors can help guide informed decision making.



Enhancing IPC: Correctly processed instruments, equipment and devices are critical in both patient safety and IPC. Reusable devices require thorough cleaning, disinfection or sterilization, clear work flows and properly trained staff, along with adherence to strict processing protocols, and rigorous quality control to ensure patient safety when used on multiple patients. In contrast, single use disposable devices are designed for one time use and are discarded after each procedure, potentially reducing the risk of cross-contamination. The choice between reusable and single use disposable instruments should be guided by a comprehensive assessment of IPC goals, staff expertise and patient safety priorities.

Streamlining Logistics, Workflow and Operations: Reusable instruments require a dedicated infrastructure for reprocessing activities, tracking and storage, including specialised equipment and staff, and strict adherence to manufacturer's IFUs and regulatory standards. This can create bottlenecks in clinical workflows during peak hours or emergencies, or when there is insufficient inventory.

Disposable single use instruments removes many of these logistical requirements as there is no need for reprocessing. Delays due to unavailable or improperly processed instruments would be reduced, staff would be available to perform other clinical duties, and inventory management would be straightforward. Unused, duplicate reusable instruments would be eliminated and reusable instruments that expire under time related sterility would no longer be reprocessed.

Some instruments may not be available as single use disposables, or the device feel and clinical performance of an instrument may not be satisfactory. In this case, organisations may benefit from a hybrid approach using a mixture of reusable and single use instruments. This would potentially allow a smaller reprocessing area, less duplication of reprocessing equipment, and less reprocessing staff.

Financial Considerations: Healthcare organisations need to analyse the financial considerations of switching from reusable to disposable instruments. Whilst the cost of disposable instruments may be higher than reusable instruments, this must be evaluated against the ongoing costs related to processing, maintenance, repair and eventual replacement of reusable instruments as well as the ongoing costs relating to reprocessing equipment and staffing. The potential financial impact of healthcare associated infections (HAI) due to improper reprocessing must also be considered.

Environmental Impact: One of the primary concerns about disposable equipment is its environmental footprint. Single use items contribute to medical waste, which must be carefully managed to avoid ecological harm. Reusable instruments also have environmental costs. The energy, water and chemicals used for reprocessing, and the infrastructure required for reprocessing all contribute to a facilities environmental impact. The wear and tear on reusable devices often leads to frequent replacements, generating waste in the form of broken or outdated equipment. Recent innovations in disposable technology are helping to address environmental concerns, such as biodegradable materials, recyclable packaging and recycling programs for disposable instruments.

Regulatory Compliance: Disposable equipment offers a straightforward path to regulatory compliance by eliminating many of the variable associated with reprocessing instruments, e.g., validation of steriliser cycles. The simplification from single use instruments reduces the administrative burden and lowers the risk of non-compliance. Proper management of reusable instruments can also support regulatory compliance and create long term cost savings and environmental sustainability.

Overall: A healthcare facility's decision on implementation of disposable instruments requires a thorough evaluation of all aspects of logistical, financial, environmental and regulatory considerations related specifically to each facility and the type of services provided. A balance of safety, sustainability and efficiency in a complex and evolving healthcare environment will mean different decisions for individual healthcare facilities. Some will achieve the desired outcome using reusable devices, some using single use devices, and some using a combination of both.

Read the full article HERE

IN FOCUS

How do hospital policy and practice for PIVCs match the ACSQHC Clinical Care Standards?

The Australian Commission for Safety Quality and Health Care's (ACSQHC) PIVC Clinical Care Standard '*Management of Peripheral Intravenous Catheters Clinical Care Standard'* sets an expected level-of-care. Researchers (Lovegrove et al., Inf Dis Health Oct 2025) conducted a point prevalence study in 21 Queensland public hospitals across 8 health services to examine the quality of PIVC care by measuring adherence to the PIVC Clinical Care Standard.

The Standard has 10 Quality Statements measured against 4 structural and 9 process indicators. Researchers added a further 6 study measures. Researchers mapped hospital policies against the Standard's structural indicators and mapped clinical practice against the Standard's process.

For the Standard's four structural indicators, overall adherence in 21 hospitals ranged from 19% to 43%. For the Standard's nine process indicators, there was a range of performance ranging from 8.7% to 79.8% conformance.

The authors conclude much unwarranted variation exists in policy and practice around PIVC management and that reform of local guidelines, policies, and processes to standardise PIVC care across hospitals and strategies to improve Standard adherence are needed.

Read the full article HERE

WHAT'S NEW

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

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Content Update: HPU 190 Sterilizing Services and Endoscope Reprocessing Units

An updated revision of HPU 190 Sterilizing Services and Endoscope Reprocessing Units (Revision 8.0, October 2025) has been uploaded to the AusHFG website. This review was focussed on updates to align with the Australian/New Zealand Standard AS 5369:2023 "*Reprocessing of reusable medical devices and other devices in health and non-health related facilities*". A full review of HPU 190 will be undertaken at a later date, in line with the five-year review cycle for AusHFG resources, acknowledging that the last full update was completed in 2022.

The revised version has been informed by extensive consultation with clinical, operational and technical experts including infection prevention and control advisors.

Key changes to the document include:

- Updates to terminology throughout the guideline to align with AS 5369
- Clarification throughout the document that pass through reprocessing equipment should be included in new or refurbished facility design. It is noted that pass-through sterilizers are best practice and should be provided, however they may not be practical in all circumstances, and it is still accepted practice in small facilities to have single door opening machines. Where pass-through sterilizers are not provided, the design shall ensure effective segregation of cleaning and dirty activities and unidirectional workflows from dirty to clean activities
- Clarification that when purchasing new reprocessing equipment, Reusable Medical Devices (RMDs), other devices and related accessories, the TGA requirements must be reviewed and items included on the Australian Register of Therapeutic Goods (ARTG)
- Updates to the information relating to point of use reprocessing to meet the requirements of AS 5369
- Minor revisions to the recommendations regarding cleaning sinks and hand wash basins in these units to align with the wording in AS 5369
- Additional guidance relating to ventilation requirements with reference to Figure A5.6.15 within AS 5369 relating to ventilation design and operation, and ACSQHC, 2022, "*Optimising ventilation for infection prevention and control in healthcare settings*"
- Updates to information relating to the transport of used RMDs

- Emphasis on the need to consult with local sterilizing/reprocessing staff as well as Infection Prevention and Control experts when planning and designing these units to understand local service requirements.

AAMI TIR109:2025; External Transport Of Reusable Medical Devices For Processing



External transport of healthcare processed items has increased due to logistical and financial reasons. Whether the transport is across the street, or across town there have been numerous concerns regarding the safety and effectiveness of this practice.

There are many significant facets to external transport that include maintaining the integrity of processed items and following safety precautions for contaminated items, protecting personnel and the environment from contaminated items and preventing breakage of medical devices.

This document provides guidance for health care facilities and offsite reprocessing centres for the external transportation of processed medical devices between these facilities (e.g., from one health care facility to another, or between offsite reprocessing centre and health care facility). It provides guidance on maintaining the integrity of sterilized items and transport for contaminated and processed items. It provides a section describing quality system considerations so that work practices and environmental controls maintain the integrity of the product and minimize the potential for contamination of used devices.

It is recommended that the healthcare facility has a policy that describes documentation and records, identification and traceability of instruments, inspection and release procedures, safety procedures, training procedures, and supplier controls and monitoring.

The selection criteria of the correct transport carrier is provided. The transport carrier is used to prevent contamination to or from the external environment and prevent items from being damaged. It should remain closed during transport with a latching mechanism and tamper evident seals. Maintaining the cleanliness of the carrier is also discussed. All transport carriers should be clearly labelled with the processing status, identifying if the items are clean, sterile, or contaminated. The containers should detail what is contained, where it came from and is going to, along with the date and time.

The area used to transport items is referred to as the cargo space, which is an enclosed area within the vehicle. There is a listing of requirements for the cargo space that includes protecting the cargo

from significant changes in temperature and humidity. This document includes environmental and cleaning considerations for the transport vehicle.

If an outside transport company is used the healthcare facility should have a process in place to regularly evaluate compliance.

Read the full article HERE

UPCOMING EVENTS



The full program is out now. Visit the program website for full details

REGISTRATIONS NOW OPEN



To book, please click the link below:

FIND OUT MORE

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

2026 Seminar Series Calendar



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

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