OFFICE-BASED PRACTICE

Message from Our Team

Dear Colleagues,

Welcome to the inaugural edition of our seasonal infection prevention and control (IPC) office-based practice newsletter.

The purpose of bringing these newsletters to you is to provide you with information and updates on contemporary IPC issues that may be relevant to your workplace. We hope you find the information informative and useful.

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).

In this issue we highlight a selection of articles addressing a wide range of IPC topics such as variables in use of different cleaning cloths and disinfectants, to the effect of toilet seat design on “toilet plume”. 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. This ties in with an advisory document from the Primary and Community Healthcare Standards designed to assist services transition from AS/NZS 4815:2006 to AS/NZS 5369:2023. In addition, there are many items of interest including an article written by an IPC Practitioner reflecting on two decades of practice and the changes she has experienced, which will bring back memories (fond or otherwise) for those who have been involved in IPC for some time. We also look at antimicrobial prescribing trends in primary and community healthcare settings over a nine year period.

Give our word puzzle a try, it is designed to get you thinking about the overall goal of IPC, no matter what the setting.

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.

" Firstly, a little bit about us."

Hands-On Infection Control commenced business in January 1998. The business was borne out of the desire to improve access to advice and support on infection prevention and control issues for those out-of-hospital health services in Western Australia who at the time did not have the expert or proficient level of knowledge and skill capacity within their own organisations. Hands-On Infection Control is a boutique independent infection prevention consultancy, education and immunisation service providing advice and guidance to health and human service, education and training organisations throughout metropolitan, rural and remote Australia, and beyond.

The Hands-On Team possesses a philosophical belief in the importance and necessity of infection prevention and management principles and evidence-based practices that are of a multidisciplinary nature.

The Consultants and Advisors have the knowledge and motivation necessary for their safe and effective implementation in the workplace, resulting in favourable outcomes for the customer.

We can provide consultation within a wide range of health and related settings including community, residential and inpatient and ambulatory centres such as day hospitals; medical, dental and other office-based practices performing skin penetration procedures; personal, rehabilitation, children and hospitality services; correctional facilities; corporate offices; early childhood education centres, the aviation industry, cleaning and laundry contract companies; and volunteer and training organisations. A small team of IPC and sterilisation consultants and advisors, immunisation nurses, administration staff and a project officer support our clients to achieve their desired outcomes.

We are proud to offer a wide range of infection prevention and control comprehensive services to meet the specific needs of our individual clients in a variety of settings. This includes but not limited to, mentoring IPC leads, development and review of fit for purpose policies and procedures, program systems reviews, environmental and work practices risk assessments, administration of adult employee immunisation programs, education, training and competency activities, infection surveillance analysis, building construction and renovation advice, and special project consultation (e.g. accreditation, licencing/relicensing preparation).

If you have any queries or would like to discuss requirements and options for your service please contact us.

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.

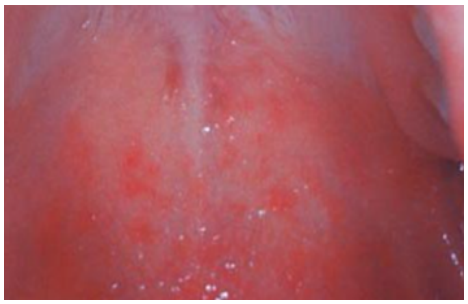
The MMR vaccine is highly effective—two doses provide 99% protection against illness and serious health complications. Most Australians receive these two doses as part of the National Immunisation Program (NIP) Schedule at 12 and 18 months of age.

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.



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) 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

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.

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

IN THE LITERATURE

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

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

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

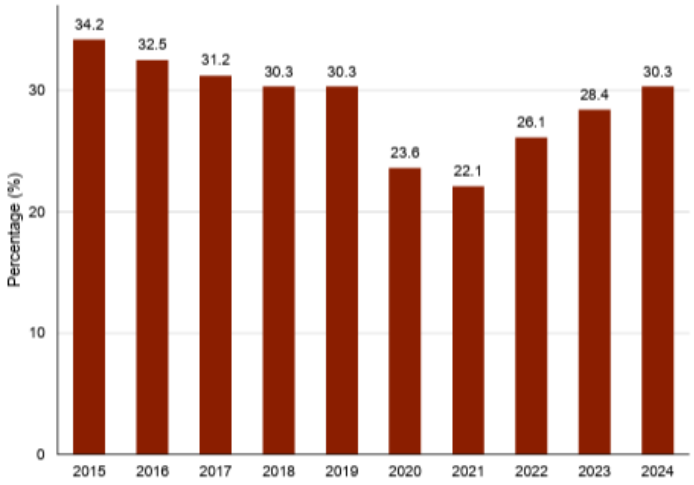
ACSQHC Antimicrobial Use and Resistance in Australia (AURA): Antimicrobial use in general practice 2015 – 2024

This technical report presents highlights of MedicineInsight data analyses on antibacterial use and appropriateness in the Australian general practice from 2015 to 2024. The MedicineInsight program is designed to enhance the quality of primary care in Australia and captures prescribing data from participating general practices across Australia including data on private prescriptions and reasons for prescriptions. Community prescribing in general practice, community health services, aged care homes and other non-hospital settings accounts for the majority of antimicrobial use in human health in Australia – the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme (PBS/RPBS) are estimated to account for more than 90% of prescriptions issued in the community.

Antimicrobials are an integral component of healthcare delivery and need to be readily available and effective. The more widely antimicrobials are used, the more likely it is that microorganisms will develop resistance. Antimicrobial resistance (AMR) is a critical risk to patient safety as it reduces the number of antimicrobials available to treat infections. It is a public health priority due to its serious and growing impact. AMR increases morbidity and mortality associated with infections caused by multidrug-resistant organisms. Hundreds of people in Australia die each year as a result of AMR.

The emergence of AMR and consequent reduction in the efficacy of antimicrobials has resulted in significant impacts on individuals receiving treatment for infections, and more broadly as AMR spreads through the community. As antimicrobials become ineffective, important treatments such as organ transplantation, a range of major surgical procedures, and chemotherapy for cancer may become limited, or no longer viable. Antimicrobial use also contributes to healthcare-associated impacts on the environment. Since 2015, there has been an overall downward trend in antimicrobial use in the Australian community sector supplied under the Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme (PBS/RPBS). However, it is an ongoing concern that antimicrobial use has trended up from 2022. These findings are consistent with analyses of antibacterials prescribed in general practices that participate in the MedicineInsight program.

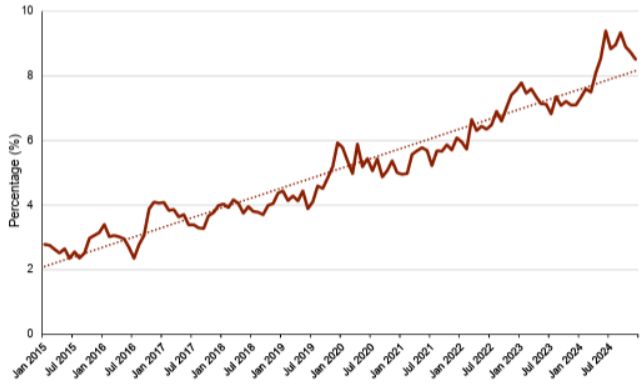
Figure 1 Percentage of patients prescribed one or more antibacterials in each year, MedicineInsight practices, 2015–2024



Source: MedicineInsight

While the exact quantity of antimicrobials dispensed privately is unknown (that is prescriptions not subsidised under the PBS/RPBS), MedicineInsight data have shown there has been an increasing proportion of private antibacterial prescriptions issued by general practitioners. In Australia, an unknown quantity of antimicrobials is supplied over-the-counter without a prescription and via expanded scope of practice by a range of registered clinicians.

Figure 3 Percentage of total antibacterial prescriptions that are issued as private prescriptions, MedicineInsight practices, 2015–2024



Note: Antibacterial prescriptions (original plus repeat prescriptions) that are private (not subsidised by the PBS/RPBS) as a percentage of total antibacterial prescriptions (original plus repeat prescriptions).
Source: MedicineInsight

Key findings and trends: MedicineInsight (2015–2024)

- Almost 1 in 3 patients were prescribed at least one antibacterial in 2024; consistent with pre-pandemic levels in 2018 and 2019
- Private antibacterial prescriptions more than tripled from 2015 to 2024 (2.7% to 8.5%); private azithromycin prescriptions notably increased in 2024
- Cefalexin, amoxicillin, doxycycline and amoxicillin–clavulanic acid remained the most frequently prescribed antibacterials in 2024
- Antibacterial prescribing rates for respiratory-related illnesses remain higher than guideline recommendations.

It is encouraging that overall antibacterial prescribing in general practice 2024 has remained below pre-pandemic levels. However, the upward trend is concerning particularly with the increasing proportion of private antibacterial prescriptions issued by general practitioners as Australia lacks robust reporting on non-PBS/RPBS antimicrobials.

Read the full article HERE

National Safety and Quality Primary and Community Healthcare Standards Advisory: Transitioning from AS/NZS 4815:2006 to AS/NZS 5369:2023. Identifying changes and implementation strategies for healthcare services

This document was developed to assist healthcare services to implement the updated and new requirements introduced in ***AS/NZS 5369:2023 Reprocessing of reusable medical devices and other devices in health and non-health related facilities***.

Action 3.13a of the **Preventing and Controlling Infection Criterion of the National Safety and Quality Primary and Community Healthcare Standards (Primary and Community Healthcare Standards)** requires healthcare services, where reusable equipment, instruments and devices are used, to have processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines. In December 2023, AS/NZS 5369:2023 superseded *AS/NZS 4815:2006 Office-based health care facilities - Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment* and *AS/NZS 4187:2014 Reprocessing of reusable medical devices in healthcare services*.

AS/NZS 5369:2023 specifies the requirements for the effective and safe reprocessing, storage, handling, and transportation of reusable medical devices (RMDs) and other devices used in human health care and other treatments. Implementation of AS/NZS 5369:2023 is required in all healthcare settings as well as other non-healthcare settings where RMDs and other devices are in use.

AS/NZS 5369 is significantly different to AS/NZS 4815 and AS/NZS 4187 and transitioning requires some key changes which have resource implementation for primary and community healthcare services. Where critical and semi-critical RMDs and other devices are used, healthcare services should conduct a gap analysis using a risk-based approach to determine changes that are necessary to align with the new requirements in AS/NZS 5369:2023. Healthcare services should update or develop an asset management plan, including timelines for future redevelopment or upgrade to their reprocessing service to meet the requirements of AS/NZS 5369:2023.

This document details the updates and new requirements and provides suggestions for implementation strategies. Has your organisation conducted a gap analysis?

View the full advisory HERE

WHAT'S NEW

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

Since September 2025 an online notification form for clinicians to report notifiable diseases and related conditions has been 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

RACGP Standards for General Practice (6th Edition)

RACGP

The consultation period for the 6th edition has now closed and the updated standards are due for release early 2026. The development of this edition was guided by the quintuple aim of healthcare – improving patient experience, population health outcomes, cost-efficiency, provider wellbeing, and health equity – and all five elements are reflected throughout the Standards.

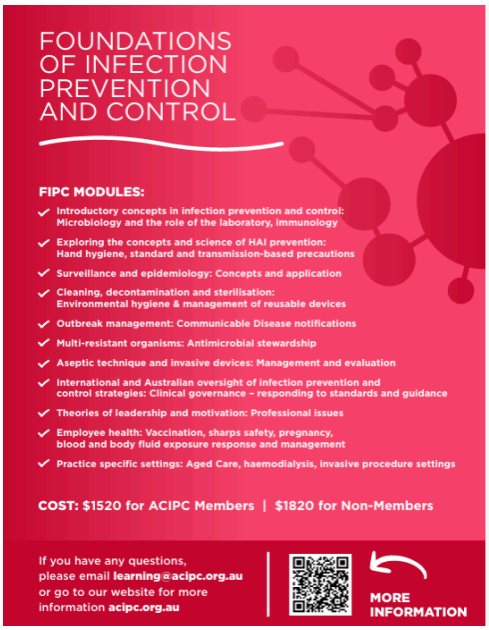
Criterion CG9.E has been introduced to the sixth edition Standards and is relevant to any practice that reprocesses reusable medical devices (RMD). It asks that the practice:

- includes in the practice-specific infection control policy details of risk assessment for reprocessing reusable medical devices
- reprocesses reusable medical devices in accordance with the RACGP Infection prevention and control guidelines or another model that meets the current Australian standard.

The sixth edition Standards also requires the practice to have a process to record sterilisation load numbers for each patient when sterile items have been used (Criterion CG9.F).

A draft version of the standards has been released.

UPCOMING EVENTS



The Australasian College for Infection Prevention and Control (ACIPC) runs numerous education events throughout the year:

Lunch and Learn Webinars

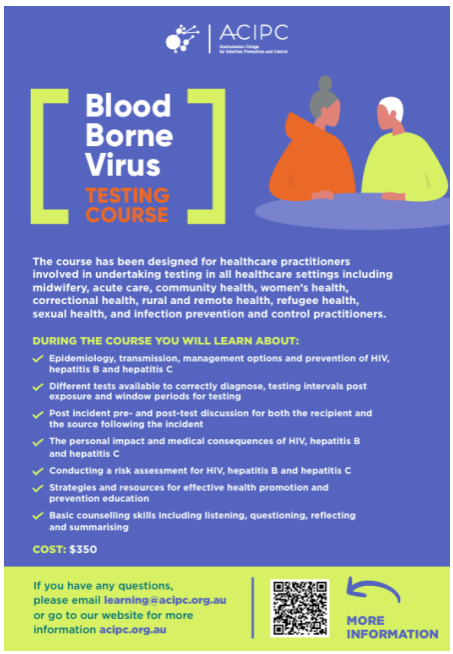
Present a wide assortment of topics relevant to different healthcare settings.

Foundations of IPC Course

This course provides a valuable pathway for IPC learning and is an important resource for those wishing to pursue a career as an infection control professional.

Blood-Borne Virus Testing Course

This course is suitable for healthcare practitioners involved in undertaking HIV and hepatitis testing in all healthcare settings including midwifery, acute care, community health, women's health, correctional health, rural and remote health, refugee health, sexual health, and infection prevention and control practitioners. The next available course commences on 17 July 2026.



Reprocessing of Reusable Medical Devices Video Series



1. General Definitions



2. Introduction to AS5369:2023



3. AS5369:2023 Framework



4. Pan Sanitiser Requirement



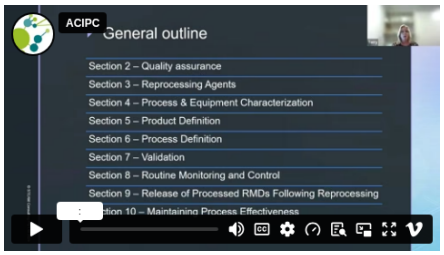
5. Intro to Chemical Disinfection



6. From ‘Soiled’ to ‘Ready for Use’



7. Science of Steam Sterilization



8. General Outline

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





Register HERE

Health Related Awareness Days 2026

- **24 March:** *World Tuberculosis (TB) Day*
- **24-30 April:** *World Immunization Week*
- **5 May:** *World Hand Hygiene Day*
- **12 May:** *International Nurses Day*
- **28 July:** *World Hepatitis Day*
- **13 September:** *World Sepsis Day*
- **17 September:** *World Patient Safety Day*
- **18-24 October:** *Infection Prevention and Control Week*
- **18 – 24 November:** *World Antimicrobial Resistance (AMR) Awareness Week*
- **1 December:** *World AIDS Day*

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

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