



ACIPC

Australasian College
for Infection Prevention and Control

IPC News

JANUARY 2024

ACIPC President Stéphane Bouchoucha

Welcome to the January 2024 Edition of IPC News.

I hope you managed to get some well-earned rest towards the end of the year and reconnect with your kinship, the support network that allows us to face challenges months after months. I prefer to use the word kinship rather than family, as family these days is much more than just relatives. There are many people in my life that have supported me, mentored me, heard my challenges and heartbreaks and offered non-judgemental support, and I am sure I am not the only one in this position. For me the end of the year is always an opportunity to reflect on the past year and be grateful for my support network. I realise that the end of the year and a new year can also be challenging for many, especially in our line of work, in the context of an unrelentless pandemic, and I would encourage you to look at the resources compiled by the **Black Dog Institute** if you need.

The beginning of a new year is also for many the opportunity to look forward and set new challenges, resolutions and initiatives. I am often over-ambitious when setting my goals for the next year and tend to beat myself up when I don't achieve what I set out. This year, I have decided to go on a different path, set new challenges, yes, but also resolve to be kind with myself and others if I fail to fully achieve my initiatives/new challenges/resolutions. This doesn't mean that I won't try, but that I will celebrate achievements more as I discussed in the December newsletter, I will be kinder with myself. Kindness has many benefits and can help us in our daily lives to prevent many ill effects of our busy work life¹.



Early in February, your board of directors will be meeting face-to-face over a weekend, to plan our strategy for 2024, in keeping with the published strategic plan. We will discuss priorities for 2024 and ways we can celebrate our members' achievements a little more during our annual conference. Planning for the conference is already well underway and the conference committee held its first meeting this month. I am already looking forward to seeing many of you there.

I am also extremely pleased with the response we had to our mentoring program implementation, the number of members signing up to be mentors and mentees far exceeded our expectations and we will be formally launching the program on 7th February, so mark your calendars and make sure you keep up to date with the college communications. Also keep your calendars handy to pencil in the many webinars and SIG meetings that we are planning this year, we have a dynamic calendar in the works to facilitate knowledge exchange and networking. Stay tuned for detailed announcements and registration information.

Finally, what makes ACIPC is you, our members, and I would like to encourage you to communicate with us. We value your input and if you have suggestions, feedback, or ideas on how we can further enhance ACIPC, please don't hesitate to reach out. Your insights are integral to our ongoing commitment to excellence. You can reach out to me at **president@acipc.org.au**

Thank you for your continued support of ACIPC, and I look forward to a year filled with shared successes and growth.

Best wishes

Stéphane Bouchoucha

¹ Boulter, J., Orozco Morales, M.L., Principe, N. and Tilsed, C.M. (2023), What is Kindness in Science and why does it matter?. *Immunol Cell Biol*, 101: 97-103. <https://doi.org/10.1111/imcb.12580>



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MEET THE BOARD

DR SALLY HAVERS

**PRESIDENT-ELECT & CHAIR –
GOVERNANCE & RISK COMMITTEE
CICP-E**



ACIPC is pleased to welcome our four new Board members, Sally Havers, Margaret Leong, Catherine McGovern and Matthew Mason. Over the next few months we will be introducing them to you. This month, please meet our new President-Elect, Sally Havers.

Dr. Sally Havers is a committed infection control professional of fifteen years, with a passion for improving and ensuring safe patient care. She has extensive experience and post-graduate qualifications in healthcare management and policy implementation, and an in-depth understanding of the current challenges and opportunities ahead of IPC practice.

Dr Havers has experience managing large, multisite infection prevention and control services and extensive project management experience in the development and roll out of a large national infection prevention program.

She has also coordinated multidisciplinary research and project teams, with an active commitment to infection control and infectious diseases research, both nationally and internationally.

Dr Havers is a Fellow of the College and has been credentialled at Expert Level with the Australasian College of Infection Prevention and Control.



RECENTLY CREDENTIALLED & RE-CREDENTIALLED MEMBERS

The board of directors would like to congratulate the following members who have received credentialling this month:

Expert re-credentialling: Sue Grieg

For information on how you can become credentialled, visit the ACIPC website:
<https://www.acipc.org.au/credentialling/>



MEMBER PROFILE CHRISTINE HUNT



This month, we chat with Christine Hunt, who is Compliance Consultant at Eldercare Australia.

How long have you been in IPC, and what drew you to it?

I have been a registered nurse since 1976. After graduating from my hospital-based training I worked in a variety of acute surgical/medical roles at major public hospitals. I did my midwifery in 1979 and worked in this area for a few years. In 1986 I completed my bachelor degree in nursing. I started in the IPC role in 1989 whilst working as an RN at a small private hospital. They needed someone to 'do' infection control for accreditation! I was working three days a week and was ready to take on some extra responsibility, so I said yes without really understanding what was involved. HIV/AIDS had emerged as a major infection control challenge, and we were in the midst of moving to universal precautions. Staff did not really understand how the disease was transmitted and how using the new precautions would work, and they were fearful of getting the disease when caring for patients. The desire to assist staff come to terms with a new way of managing the risk of infectious diseases, and be confident in their practice, was what sparked my interest. This, along with the fascinating world of microbiology, was the beginning of my long-held passion for all things infection prevention and control.

I joined the state-based infection control association and found my people - they enjoyed taking about infections and how to prevent them as much as I did! I am still connected to these colleagues today and value their support and friendship over the years.

Keen to learn more about this fascinating area I undertook the Graduate Certificate in Infection Control at Griffith University under the expert tutelage of Deborah McBeth. This stood me in good stead to move into more senior IPC roles in both public and private hospitals. From there I moved to the role of Infection Control Nurse Advisor in the Infection Control Service within the Communicable Disease Control Branch for the South Australian Department of Health, where I worked for six years before moving to Eldercare in 2008. From these very early days I have always been an active member of the then Australian Infection Control Association (now ACIPC), and spent a short time helping to set up the initial AICA ICP Credentialling Program. This process has of course been much improved and streamlined since then.

In 2015 I completed a master's in clinical science at Adelaide University, which included conducting a systematic review into the risk factors associated with antibiotic resistant organism carriage in residents in residential aged care facilities.



Can you tell us a bit about your current role? What does the average day look like for you?

I have worked for Eldercare (a large not-for-profit residential aged care provider in South Australia) for 16 years. I have held a few different management roles, none of them exclusively in IPC, although given my experience I am often called on to provide advice and support to the clinical teams at sites.

By 2021, as with many of my colleagues, the COVID pandemic in Australia completely changed my career trajectory and rather than slip into a relaxed retirement I was needed as part of Eldercare's COVID Action Group. I was now in a casual role as a compliance consultant and at the beginning of the pandemic we spent many hours planning to prevent, then to manage, the inevitable outbreaks at our residential care sites. At this stage I also took on a part time role back with the South Australian Department of Health as part of the COVID Operations Infection Control Service, providing an aged care perspective.

Several years and many outbreaks later, my role has changed again, working only one day a week. My job is to assist the Eldercare Governance, Risk and Compliance Team with a variety of compliance requirements, including those related to infection prevention and control. This sees me working closely with the site-based clinical teams generally, and specifically with the newly established IPC Leads at each of our 12 sites. I am still part of the organisation's COVID Action Group and assist with maintaining and reviewing our Pandemic Response Plan. In addition to this I have a lead role in maintaining our Rainbow Tick Accreditation.

So on any day at work, I would be liaising with the COVID Coordinator, perhaps attending meetings of the COVID action group or the IPC Leads Network, providing advice to a site on a COVID or gastroenteritis outbreak, preparing for an upcoming accreditation, reviewing the IPC program, policies and procedures, planning the next Hand Hygiene Day or Pride march! So I would say a very varied day and never, ever boring!

What are you passionate about in the field of IPC?

When I first went to work in aged care, I quickly became aware that IPC did not have the same kind of focus that it did in the acute care system. Whilst the workforce consisted of registered and enrolled nurses, the majority of staff were relatively untrained carers whose knowledge of IPC was limited.

I firmly believe that knowledge is power and throughout my career I have seen my role as one of empowering health and aged care workers, patients/residents and their families to understand how infections are transmitted, and the basic principles of preventing or at least controlling them. This includes things such as hand hygiene, vaccination, and the responsible use of antimicrobials.

Because of this, training, education, and mentoring have been a consistent priority of mine. I also am passionate about using data to change practice. ICPs collect a lot of data, but if you don't analyse it regularly and thoroughly, and interpret the results correctly, you will never improve. You don't know what to fix if you don't look for it, and look at it closely. I have always tried to encourage others responsible for clinical care to collect meaningful and accurate data, and then look at it critically before deciding on what action, if any, to take.

MEMBER PROFILE CHRISTINE HUNT

You have had a long career, what have been the highlights (or lowlights) and has progress in IPC made you feel optimistic about the future of IPC in aged care?

Since my first tentative steps in the role back in the 1980's I have seen lots of changes in IPC as we have gained more insight into disease transmission and research has clarified new ways of working. These have been positive steps which have improved the lives of many Australians. Things like the introduction standard precautions, improved vaccination programs and antimicrobial stewardship have contributed to this impact.

Like HIV/AIDS in the 80s, the COVID pandemic has been a career defining moment for me. As the progress and implications of the disease on aged care residents unfolded and I was desperately trying to prepare staff and residents for the inevitable and minimise the impact, a work colleague said to me "you are enjoying this aren't you?" He was of course incorrect, I certainly was not enjoying it, but I did have a sense that I had been preparing all my working life for just such an event and that I had the knowledge and experience to make a positive contribution and potentially save lives.

For me one of the great things to come out of the COVID pandemic is the advent of the IPC Lead role in aged care. In November 2020, the Commonwealth Government announced the requirement for all RACFs to appoint a trained IPC Lead at each aged care facility; this was a game-changer for aged care. For Eldercare it means we now have at least 12 registered nurses who have been given the opportunity to increase their knowledge and enhanced their ability to make improvements in IPC at their site.

However, whilst there is absolutely no doubt that the introduction of IPC Leads is the best thing that has ever happened to Infection Control in RAC in my working career, this great leap forward has not been without its issues and challenges. The new IPC Leads are very much novices. In order to ensure their ongoing success it's vital that all IPC Leads are provided with ongoing training and support. It's also imperative that aged care providers support their IPC Leads with time and opportunity for ongoing learning and professional development. I believe that membership of ACIPC and access to their conferences, workshops and journal also help support IPC Leads in their role. Despite the challenges, the IPC Lead role is definitely a positive step for IPC in aged care. This makes me feel optimistic that the sector is in better hands now than it ever has been.

How do you like to relax and unwind after a long day? Any hobbies or pastimes you could share with us?

Being semi-retired means I have time to pursue some other interests like volunteering for a local gardening group, Pilates classes and a movie club. I also enjoy reading and knitting (although I am a bit slow at both). I have four grandchildren who I love spending time with and keep me busy. I also have a five-year-old Cavoodle who loves me to walk him on the beach every day!

I am passionate about LGBTIQ+ rights and work as a volunteer advocate for residential care residents to support them through their transition to aged care. I still love going to work each week and feel like I am able to contribute meaningfully to maintaining the organisation's IPC Program and supporting the IPC Leads in their role.

Veterinary Foundations of Infection Prevention and Control



NEW COURSE IN 2024

We are pleased to announce an exciting new course being added to the suite of ACIPC's educational offerings - **Veterinary Foundations of Infection Prevention and Control (VFIPC)**.

Commencing 1 March 2024, this groundbreaking course is designed for all veterinary staff worldwide and aims to provide students with a broad understanding and introductory skills to enable them to assess, plan, implement and evaluate infection prevention and control activities within their veterinary workplace.

With 11 self-paced modules running over approximately six months, VFIPC allows participants to apply knowledge to their own practice, and is a key component to achieving the ACIPC Primary Credential (CICP-P).

The program has been designed to accommodate busy work schedules, with a series of self-directed learning units supported by a structured online curriculum.

Topics include:

- environmental hygiene
- outbreak management
- employee health
- surveillance
- epidemiology and microbiology

This course reflects recent evidence, guidelines and standards.

Cost

- \$1520 for ACIPC members
- \$1820 for non-members

Scholarship opportunities available.
Courses commence 1 March 2024

BOOK NOW
FOR THE COURSE
COMMENCING
1 MARCH 2024

If you have any questions,
please email learning@acipc.org.au
or go to our website for more
information acipc.org.au




**APPLY
HERE**

BOOK NOW
FOR THE COURSE
COMMENCING
1 MARCH 2024

*LIMITED
SPACES
LEFT*

Blood Borne Virus

TESTING COURSE



The course has been designed for healthcare practitioners involved in undertaking 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.

DURING THE COURSE YOU WILL LEARN ABOUT:

- ✓ Epidemiology, transmission, management options and prevention of HIV, hepatitis B and hepatitis C
- ✓ Different tests available to correctly diagnose, testing intervals post exposure and window periods for testing
- ✓ Post incident pre- and post-test discussion for both the recipient and the source following the incident
- ✓ The personal impact and medical consequences of HIV, hepatitis B and hepatitis C
- ✓ Conducting a risk assessment for HIV, hepatitis B and hepatitis C
- ✓ Strategies and resources for effective health promotion and prevention education
- ✓ Basic counselling skills including listening, questioning, reflecting and summarising

COST: \$350

If you have any questions,
please email learning@acipc.org.au
or go to our website for more
information acipc.org.au



**MORE
INFORMATION**

SHORT
COURSE

LIMITED
SPACES
LEFT

BOOK NOW
FOR THE COURSE
COMMENCING
6 FEB 2024

INFECTION PREVENTION AND CONTROL IN AGED CARE SETTINGS

WHAT IS THE COURSE FOR?

This course is designed to provide staff with the fundamental principles and concepts of infection prevention and control practice as they apply to various Aged Care settings in particular Residential and Community Aged Care settings. This is a course for RNs and EN/EENs supporting Aged Care IPC Clinical Leads. This course is also suitable for Facility Managers needing up-to-date best-practice IPC knowledge and skills.

The modules can be undertaken over a six-to-eight-week period and a certificate of completion will be issued to students who complete the course.

MODULES INCLUDE:

- ✓ Principles of Infection Prevention and Control
- ✓ Management of the environment, resident and staff health
- ✓ Management of invasive devices, hygiene and aseptic techniques
- ✓ Management of outbreaks
- ✓ Organisms of significant AMS
- ✓ Governance and leadership

COST: \$500

If you have any questions,
please email learning@acipc.org.au
or go to our website for more
information acipc.org.au



**MORE
INFORMATION**



11TH INTERNATIONAL CONGRESS OF THE **ASIA PACIFIC SOCIETY OF INFECTION CONTROL (APUSIC)**

APUSIC have announced their 11th International Congress of the Asia Pacific Society of Infection Control for 2024.

Date: 25th – 28th July 2024

Venue: Shangri-La Hotel, Jakarta, Indonesia

This conference will be an excellent meeting with great scientists from different countries around the world and to share new and exciting results on the impact of COVID-19 on Infection Prevention and Control.

The theme for 2024 is Infection Prevention and Control for All: Implementation in Healthcare Settings And Community.

JOIN APUSIC AT THIS INTERESTING EVENT by:

1. Scanning the QR Code:



2. Clicking **APUSIC 2024 – Asia Pacific Society of Infection Control** for more information



ACIPC LUNCH & LEARN WEBINAR

Topic: Mould in the healthcare environment

Presenters: Sarah Bailey

Date: Wednesday 21 February at 12.00 pm AEDT

[CLICK HERE
TO REGISTER
FOR THIS
WEBINAR](#)

Abstract: Come along and enjoy your lunch while learning about mould in the healthcare environment. This webinar is an introduction to mould in the healthcare environment, how it gets there, and what you can do about preventing it and getting rid of it, and also appropriate responses to it in healthcare based on risks to patients.

Key topics are:

- What is mould?
- Health effects of mould
- Toxic black mould
- Causes of dampness
- Categories of water ingress and how to deal with them
- Pre remediation testing
- Drying
- Remediation
- Post remediation testing
- Heating, ventilation and cooling systems - how they work, and why and how they get mouldy
- Applicable Australian standards
- What to do with mouldy heating, ventilation and air conditioning (HVAC)
- Inspection of HVAC
- What to do when you find mould in your HVAC
- How to clean HVAC
- How to prevent mould in your HVAC

About the presenter



Sarah Bailey has a master's in medical microbiology and a post graduate diploma in medical mycology, and has also completed studies in infection control in the hospital environment, legionella control and asbestos. She is originally from the UK where she worked in diagnostic microbiology for many years, and she was the Legionella Control Officer for a private hospital. Sarah also been a part of several infection prevention and control teams within the hospitals she has worked in. With her move to QED

Environmental Services, she now applies that microbiological knowledge to their work in water quality and risk assessment, indoor air quality in hospitals, with cooling towers and with our other various investigations such as mould and other health issues within buildings. She is also a full member of the Institute of Hospital Engineers Australia and the Australasian College of Infection Prevention and Control.

DECEMBER LUNCH & LEARN WEBINAR

12 Days of Gastro

December's webinar had a festive feel as we learned about the 12 Days of Gastro with Belinda Andrews. Here is a summary of the webinar, which members can view on our [website](#).

Christmas means lots of things to lots of people, and can bring us joy, but it is also a time when gastroenteritis can rear its ugly head. Gastro is a serious illness, whether caused by bacteria, parasites or viruses, and has the ability to be regifted to family and friends. Not the perfect Christmas gift!

Prevalence varies across areas, so it's strongly recommended you review your local public health data and reports. The majority of illnesses are caused by infectious viruses and can cause outbreaks amongst people living in close proximity, such as daycare centres and nursing homes. People with impaired immunity are most at risk. Diarrhea diseases are the second leading cause of death in children under five worldwide, especially in places without clean drinking water or adequate hygiene practices.

Gastro is spread through contaminated foods, drinking liquids, objects or surfaces and from person to person as a result of direct contact with vomit or faeces, poor hand hygiene or through ingestion of particles in the air that have remained suspended when a person vomits. Generally, there's no treatment for viral gastroenteritis and management is largely supportive.

Treatment for bacterial gastroenteritis will depend on the organism and primarily treatment is to support symptoms.

Treatments such as anti-diarrhea agents should only be given on the advice of a medical officer, and may be prohibited with certain pathogens as they may lead to more severe illness. Often it is best to let the illness run its course.

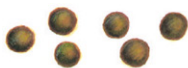






Diagnosis

Many gastro illnesses are never diagnosed, and pathogens generally cause a self-limiting illness with symptoms of nausea, vomiting, diarrhea, anorexia and weight loss. Many will never present to the GP.

Diarrhea is defined as the passing of three or more loose stools (type 6 or 7 on the Bristol Stool Chart). Image Bristol Stool Chart. Stool specimens need to be sent to the lab in a timely fashion, samples left sitting around for hours at room temperature may become unstable.

It is important to assess each case individually, especially during an outbreak. All patients should have their bowel sounds listened to, for example, so we don't miss other conditions that mimic gastroenteritis.

The Bristol Stool Form Scale

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID



***On the first day of Christmas,
my eggnog gave to me...
one week of salmonellosis***

Chicken or egg? Although chicken can be implicated in salmonella outbreaks, eggs are a common source of infections. Non-typhoidal Salmonella (NTS) has two species, Salmonella bongori and Salmonella enterica (with over 2600 serotypes). Medium annual salmonellosis notifications account for 16,375 cases annually and is the second highest notification enteric disease.

Salmonella species (excluding serotypes causing typhoid and paratyphoid) can be detected in stool, blood, urine and sterile sites. Less commonly, it causes intestinal infections lasting one week or longer.

Remember that chicken must be properly cooked, a recent survey found 84% raw chicken carcasses tested positive for campylobacter, and 22% for salmonella.



***On the third day of Christmas,
undercooked chicken gave
the family...three cases of
campylobacteriosis***

This is the most common cause of bacterial gastroenteritis in Australia, it is notifiable and investigation into the likely source is often warranted. It can cause diarrhea symptoms which are frequently bloody.

Campylobacteriosis is associated with consumption of contaminated poultry, water or unpasteurised milk. It can occur anytime of the year, but is more common in warmer months. The incubation period is 2-5 days, the infection can last for up to 2 weeks.

Treatment usually conservative but may require antibiotics (unfortunately some overseas strains are resistant to the most commonly used antibiotics). There is no vaccine available.



***On the second day of Christmas,
the local waterpark gave the
kids... 2 weeks of cryptosporidium***

Cryptosporidium is a microscopic parasite and is found in the faeces of infected humans or animals such as cattle, sheep, dogs, cats, birds, and fish. The parasite is one of the most common causes of waterborne disease in humans around the world.

Oocysts of parasite are the infectious stage and present in faeces of symptomatic people. The incubation period is 2-10 days after being infected, symptoms last 1-2 weeks and may come and go for up to 30 days. Treatment is conservative management and no vaccine is available.



***On the fourth day of Christmas,
raw seafood gave to me...
symptoms of vibrio infection***

Commonly associated with raw or undercooked seafood. It is a notifiable disease and food-borne outbreaks often go undetected as vibrio can be detectable in seafood with no implications for human health.

Infection can lead to severe diarrhea with metabolic shock and acidosis. Warm coastal tropical waters are the natural habitat. Symptoms usually start one day after infection and last three days. You can also get an infection if you have an open wound on your hand which comes into contact with raw or undercooked seafood. If infection spread to the bloodstream it can become life-threatening. Thankfully,

Treatment usually includes rehydration, IV fluids and antibiotics. Cholera vaccinations are available and recommended for travelers over two years of age who are travelling to areas where there is a high chance of exposure.

When travelling in these areas remember to:

- thoroughly cook all seafood caught in coastal and estuarine waters
- avoid eating raw oysters or shellfish from rivers, estuaries, or gulfs
- avoid swimming in these zones if immune compromised



On the fifth day of Christmas, my South-East Asia holiday gave to me...a hospital visit with typhoid fever

Typhoid fever is a life threatening infection caused by bacterium Salmonella Typhi and Salmonella Paratyphi. Usually spread through contaminated food or water, once ingested, it multiplies and spreads to the bloodstream.

Most cases are acquired overseas and symptoms include prolonged high fever, fatigue, headache, nausea and abdominal pain, constipation and diarrhea. Some people develop a rash, complications and even death. It's a public health problem in many of the developing areas of the world, including African, Eastern Mediterranean, South-East Asian and Western Pacific regions. There are around nine million cases worldwide each year, with 110,000 deaths annually.

Symptoms start 8-14 days after infection but can be up to 60 days after infection. It can be treated with antibiotics, also a vaccine is available and is recommended for travelers who are at high risk of disease. Affected people can shed bacteria for prolonged periods post cessation of symptoms and may need longer periods of isolation in healthcare settings.



On the sixth day of Christmas, my antibiotics gave to me... Clostridioides difficile

The most common cause of infectious diarrhea in patients in hospital. Complex cases can result in admission to ICU, need for colectomy or even death. Risk factors include people who have been on antibiotics, protein pump inhibitors or any immune-suppressive therapy, those undergoing bowel surgery or who have bowel disease. Not all patients develop symptoms.

Clostridium difficile toxin is tested via positive stool. Epidemic strains (Ribotype O27) have been seen in Australia and are a particular IPC issue if they start to spread in facilities. Surveillance programs across Australia monitor incidence. It's important to note that stool samples left sitting more than two hours may require recollection as C. difficile is not very stable at room temperature.

Onset can occur within 48 hours after exposure and up to three months post exposure. Treatment may include metronidazole, vancomycin for more severe cases, or dual therapy may be required. Antidiarrheal agents must be avoided as this may lead to severe complications such as pseudomembranous colitis or toxic megacolon.





On the seventh day of Christmas, undercooked beef gave to me...Haemolytic uraemic syndrome (HUS)

This is a rare notifiable disease which commonly effects children under five. Bacteria can be passed on to humans by eating undercooked beef, particularly ground or minced beef, drinking raw unpasteurized milk, close contact with a person who has bacteria in their faeces, swimming or playing in contaminated water, or contact with farm animals. Other known sources of the bacteria have included lettuce, spinach, sprouts, salami and fruit juices.

The organisms which cause HUS are shiga toxin-producing *Escherichia coli*, *Shigella*, and *Streptococcus pneumoniae*. HUS can causes microangiopathic haemolytic anaemia, thrombocytopenia, and acute renal failure.

HUS is generally treated with fluid and electrolyte replacement, treatment of anaemia, hypertension and seizures, early use of dialysis and blood transfusions. Antibiotics are generally avoided as they correlate with poorer outcomes.

Incubation periods are:

- STEC 2-10 days
- *Shigella* 12-96 hours
- Invasive pneumococcal disease 1-4 days, and HUS develops within 7 days (to 3 weeks) after onset of diarrhea

Transmission depends on the organism

- *Shigella* and STEC: faecal oral route
- *Streptococcus pneumoniae*: droplet spread, direct or indirect oral contact



On the eighth day of Christmas, the local childcare centre spread too many...Rotavirus

Rotavirus is the leading cause of severe illness in children younger than five. The double-stranded RNA virus genus *Reoviridae* is nationally notifiable. Symptoms usually start 1-3 days post infection and viral shedding can occur around 10 days. Outcomes are generally more severe in unvaccinated infants less than three months of age with fluid and electrolyte losses posing risk of shock which can be fatal.

Rotavirus is extremely contagious. Transmission is usually via oral ingestion of contaminated materials, contact with an infected person's diarrhea and vomit, and inhalation of particles during vomiting. Oral vaccine has greatly improved outcomes, and since their introduction there has been a 58 - 90% reduction in cases worldwide.



On the ninth day of Christmas, frozen strawberries on my pav gave to me...Hepatitis A

Inflammation of the liver is caused by the Hepatitis A virus, and transmission is via faecal oral route. It can be transmitted by ingestion of food or water contaminated by virus and is associated with unsafe water or food, inadequate sanitation, poor personal hygiene, and oral anal sex.

Incubation is 14-28 days and symptoms include diarrhea, malaise, loss of appetite, nausea, abdominal discomfort and jaundice. There is no specific treatment, and recovery can take months, however vaccination is available.



***On the tenth day of Christmas,
my overseas holiday gave
to me...amebiasis***

Amebiasis is not common in Australia but is the fourth leading cause of death from protozoan infection in developing countries. Intestinal and tissue parasitic infection is caused by the protozoan *Entamoeba histolytica* (8 species) and diagnosis is usually via a stool sample or blood test.

Infection occurs via ingestion of water or food contaminated by faeces containing *E.histolytica* cysts, which are resistant to disinfection and can survive in aquatic environments for months. Asymptomatic infection can occur in up to 90% of people, with only 1% developing invasive disease which can lead to intestinal disease including abdominal pain, ulcerative colitis, and diarrhea.

Extraintestinal disease can also occur, when trophozoites enter the blood, which may lead to organ involvement (hepatic and pulmonary amoebiasis). This can be fatal if left untreated, may require antibiotics and +/- drainage for source control.



***On the eleventh day of Christmas,
the portaloo or something at the
work Christmas party gave to me...
diarrhea of unknown origin***

Some outbreaks of diarrhea are unfortunately never diagnosed.



***On the twelfth day of Christmas,
visiting the local aged care facility
gave to my nanna, and her whole
wing...Norovirus***

We're all familiar with this non-enveloped, single-stranded RNA viruses of genogroups I, II, and IV which most commonly cause illness in humans. It's highly contagious and the most common cause of gastroenteritis in Australia and worldwide, and is generally spread via the faecal-oral route, or particles when a person vomits

Outbreaks in childcare centres, hospitals, residential aged care facilities or other care facilities are common. Outbreaks are defined as two or more cases of diarrhea/vomiting in 24 hours. Symptoms appear 24-48 hours after exposure, and generally last 1-2 days. Treatment is conservative, and there is no vaccine.





STAYING SAFE

- Test early on suspicion and isolate to avoid outbreaks
- Enhanced bathroom cleaning if anyone in the home or facility has diarrhea and vomiting
- Performing hand hygiene after toileting, before eating or preparing food
- Food safety at all stages shopping and transport, preparation, cooking, heating, and storage
- Carefully wash fruits and vegetables
- Don't wash your whole chickens before cooking as it can splash bacteria around the kitchen. Instead, cook it thoroughly so it is safe to eat
- Use thermometers to test if cooked rather than "self testing by tasting"
- Steam oysters before eating them
- Defrost meat or poultry in fridge or microwave in a container to prevent spills
- Clean and disinfect contaminated surfaces in the home after an episode of illness
- If you can, don't share toilets at home with someone who has diarrhea



MORE FOOD SAFETY TIPS

- Practice food safety at home and in the community
- Avoid uncooked foods, including fruit and vegetables, particularly if you are travelling in other countries.
- When shopping, ensure raw meat, poultry and seafoods are in plastic bags and kept away from other foods
- Store eggs in their original carton and refrigerate as soon as possible
- Use separate (and clean) chopping boards for raw and cooked meats
- Marinade used on raw meat should not be poured onto meat after cooking
- Cook meats at correct temperatures:
 - 75 degrees for poultry, eggs and beef
 - 70 degrees for pork
 - 65 degrees for fish
- Hot food above 65 degrees, cold food below 4 degrees and frozen food -3 degrees

TRAVEL TIPS

- Take alcohol-based hand rub with you
- Use a hot cycle in washing machine for soiled clothing
- Drink bottled or boiled water and do not drink untreated water (including ice)
- Avoid eating from street stalls with poor refrigeration and hygiene standards
- Ensure hot food is well cooked and eaten when hot
- Get vaccinated
- Do not go to work if you are a food handler, caring for children or elderly until advised by local public health unit or equivalent
- Practice safe sex

INFECTION CONTROL IS EVERYONE'S BUSINESS

(An initiative at West Gippsland Healthcare Group, Warragul, Victoria)

Infection Prevention and Control (IPC) Manager Geraldine Freriks had a vision of sharing exactly what infection prevention and control is all about. The IPC team began planning how to showcase the department's diverse roles and responsibilities.

Information tables were provided for the following topics:

- Hand hygiene (supported by SC Johnston)
- Sepsis (West Gippsland Healthcare Group IPC)
- Cleaning wipes and products (supported by GAMA Healthcare)
- Vaccination/staff health (West Gippsland Healthcare Group IPC team)
- Antimicrobial stewardship and multi-resistant organisms (West Gippsland Healthcare Group IPC)
- Mask fit testing (WGHG MFT team)
- Cleaning (supported by AGAR Cleaning Supplies)
- Peripheral Intravenous Cannulation (PIVC) (Supported by 3M and WGHG Learning and Development)

The IPC day took place in September 2023 at the WGHG staff cafeteria between 10am and 2pm. All clinical and non-clinical staff were invited to explore, gather information, pose questions, participate in quizzes, and of course, receive complimentary items. Colour co-ordinated stalls with matching balloons, tablecloths, and treats were set up for interactive and informative displays.

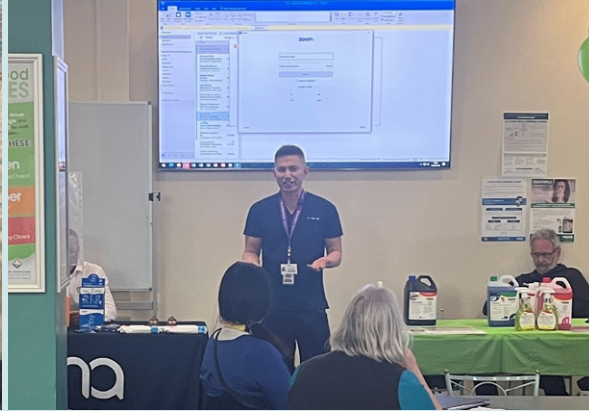
Representatives from various companies were welcomed to showcase and discuss their products and services. Complimentary morning tea and lunch was provided for all staff.

Throughout the day Dr Alex Tai, WGHG Infectious Diseases Physician, and Tim Wendt, hospital pharmacist, delivered engaging and informative presentations on anti-microbial stewardship. Clinical Nurse Consultants had pre-recorded presentations on the history of infection prevention & control, as well as PIVC Clinical Care Standards. These presentations were played on large screens, allowing staff to watch while browsing or taking a meal break. Surprise prizes were discretely placed under seats and awarded to those who stayed to listen to the

The day was a relaxed and well- attended, and effectively highlighted key focal areas for infection prevention & control, shedding the light on the extensive responsibilities carried by the IPC teams.

Alison Spragg

Infection Prevention and Control CNC



3M Science. Applied to Life.

INFECTION PREVENTION AND CONTROL IN AGED CARE WHITEPAPER

GAMA Healthcare Australia recently convened a roundtable of leading aged care infection prevention and control experts to discuss how to further improve the sector's infection prevention policies and practices.

The experts included the heads of infection prevention across numerous aged care groups (representing over 33,000 Residential Aged Care Operational Places), leaders from the Australasian College of Infection Prevention and Control, and other experts from across the sector.

The group met across four roundtables and worked to develop the Infection Prevention and Control in Aged Care Whitepaper. The Whitepaper makes eight recommendations of government.

Whitepaper recommendations:

- Provide specific guidance on IPC practices for residential and home care and how they relate to the Aged Care Quality Standards.
- Increase funding to support aged care providers to implement robust IPC measures inclusive of training and resources.
- Establish guidelines for infection prevention that are specific to residential and home-based care.
- Create and support streamlined national surveillance and reporting.
- Provide guidelines to providers on the level of ventilation required in residential aged care.
- The allocation of funding to assist providers in retrofitting heating, ventilation, and air conditioning (HVAC) systems or procuring augmented ventilation systems to meet residential care ventilation guidelines.
- Include infection prevention as a quality indicator.
- Provide support and access to training to assist providers who are not achieving the standard set out by the quality indicators to improve practices.



ACIPC
Australasian College
for Infection Prevention and Control

**CLICK HERE
TO READ
THE FULL
WHITEPAPER**

This Whitepaper has received significant support from across the infection prevention sector as well as the aged care sector since its launch at ACIPC's Annual Conference in November 2023.

While many of the Whitepaper's recommendations do not require additional funding, recommendations two, six, and eight do require additional funding to be fully realised. Investment in infection prevention can be cost effective in clinical settings, and reducing the burden of infection in aged care can cause significant reductions in treatment and care costs.

Healthcare associated infections (HAIs) result in an increased length of stay of 18.1 days, on average costing \$37,539 in additional cost¹. A point prevalence study conducted in 2019 showed that 1 in 10 patients in hospital will develop a HAI², creating a significant burden in the cost of treating patients due to increase length of stay, let alone complications.

¹ <https://www.safetyandquality.gov.au/sites/default/files/migrated/Healthcare-associated-infection-detailed-fact-sheet.pdf>

² <https://aricjournal.biomedcentral.com/articles/10.1186/s13756-019-0570-y>

INFECTION CONTROL MATTERS PODCAST

If you could have anything in IPC, what would you want?

In this week's episode Phil and Brett mull over their wishlists for what they would want in a perfect IPC world. They turn out to be a pretty undemanding pair.. not. However they both see a future in which their wishes could become true. Unsurprisingly AI and automated surveillance loom large in their thoughts.

The 2023 End of Year/Christmas Special

In our usual Christmas episode, Brett, Phil and Martin choose our papers and podcasts of 2023. Also this time, Martin set the three of us a challenge: to find an interesting IPC-related paper from the years of our birth (more challenging for some than others..). Martin also reveals the No 1 single in our respective countries on the day of our birth. For Martin, a near miss. For Phil, a very apt song and for Brett... well, his karaoke debut cannot be far off.. Happy holidays everyone!

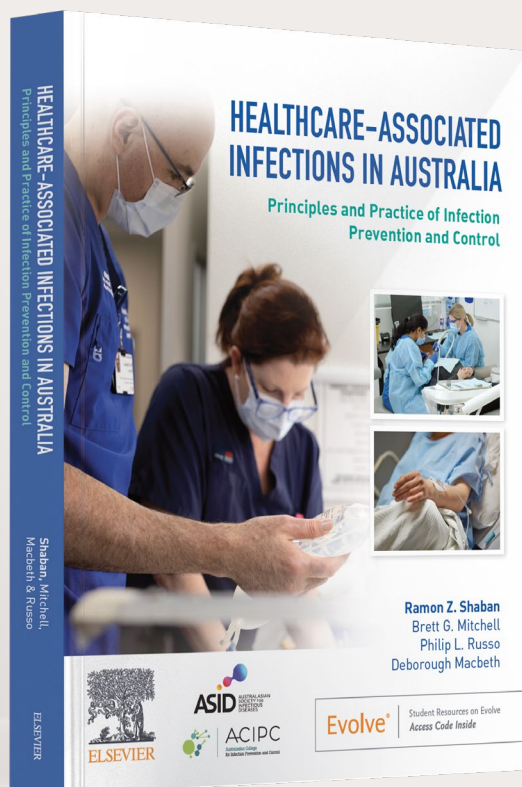


C. difficile: Disinfectants, attachment and strain variations

In this week's episode, Martin talks to Dr Tina Joshi, Associate Professor of Molecular Microbiology in Peninsula Dental School at the University of Plymouth, UK. We discuss her longstanding interest in *Clostridioides difficile* and her many publications, one of which on the effectiveness of hypochlorite (or lack of it) on spores has been widely covered in the media. We chat about spore attachment to surfaces, the effect of disinfectants and the differences between strains. Some of Tina's papers are listed here.

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The first Australian text to address the challenges posed by infectious diseases and healthcare-associated infections for all members of the multidisciplinary healthcare team.



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1st Edition

By Ramon Z. Shaban, Brett G. Mitchell,
Philip L. Russo & Deborah Macbeth
ISBN 9780729543644

Healthcare-Associated Infections in Australia

Principles and Practice of Infection Prevention and Control

Drawing on the expertise of a wide author team, and based on current research, this important and comprehensive text provides a clear pathway for the reader to increase their knowledge and understanding of IPC. The text is designed for both students and practising clinicians, and is presented in two sections - Principles and Practice - for ease of use. With IPC principles and guidelines now embedded into all health-related curricula, and mandated by standards and guidelines across all areas of healthcare, this is a book no health professional should miss.



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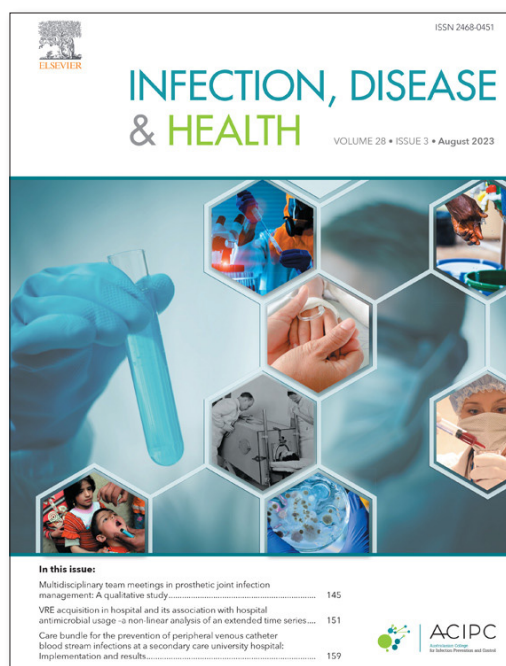
Happy shopping!

Latest articles from Infection, Disease & Health

Regulating antimicrobial use within hospitals: A qualitative study

Jennifer Broom, Alex Broom, Katherine Kenny,
Pamela Konecny, Jeffrey J. Post

[https://www.idhjournal.com.au/article/S2468-0451\(23\)00112-8/fulltext#%20](https://www.idhjournal.com.au/article/S2468-0451(23)00112-8/fulltext#%20)





Selected publications of interest

Using AI to undertake surveillance

<https://www.sciencedirect.com/science/article/pii/S2590088921000561>

Dave the hand hygiene robot

<https://www.sciencedirect.com/science/article/pii/S2590088921000779>

How Artificial Intelligence Is Revolutionizing Diagnosis in Health Care

https://www.infectioncontroltoday.com/view/how-artificial-intelligence-is-revolutionizing-diagnosis-health-care?utm_source=sfmc&utm_medium=email&utm_campaign=01182024_ICT_TOM-24-ICD0315_Surface%20Disinfection_TRC%20

SHEA/IDSA/APIC Answer to Diekema, et al, Study on Prevention of MRSA Infection and Transmission

https://www.infectioncontroltoday.com/view/shea-idsa-apic-answer-to-diekema-et-al-study-on-prevention-of-mrsa-infection-and-transmission?utm_source=sfmc&utm_medium=email&utm_campaign=01182024_ICT_TOM-24-ICD0315_Surface%20Disinfection_TRC%20

Assessing Measures for Reducing SARS-CoV-2 Transmission: Low- and High-Tech Tools and Practical Insights

https://www.infectioncontroltoday.com/view/assessing-measures-reducing-sars-cov-2-transmission-low-and-high-tech-tools-practical-insights?utm_source=sfmc&utm_medium=email&utm_campaign=01182024_ICT_TOM-24-ICD0315_Surface%20Disinfection_TRC%20

Effectiveness of reducing bacterial air contamination when covering sterile goods in the operating room setting: a systematic review and meta-analysis

[https://www.journalofhospitalinfection.com/article/S0195-6701\(24\)00006-9/fulltext](https://www.journalofhospitalinfection.com/article/S0195-6701(24)00006-9/fulltext)

Air Quality in Infection Prevention: Innovations, Efficacy, and Limitations

https://www.infectioncontroltoday.com/view/air-quality-in-infection-prevention-innovations-efficacy-limitations?utm_source=sfmc&utm_medium=email&utm_campaign=12192023_ICT_HEA-23-ICD0267_Healthmark_eNL%20

IMpleMenting Efective infection prevention and control in ReSidential aged care (IMMERSE): protocol for a multi-level mixed methods implementation study

<https://bmccgeriatr.biomedcentral.com/counter/pdf/10.1186/s12877-023-03766-9.pdf?pdf=button%20sticky>

Identifying barriers and enablers to participation in infection surveillance in Australian residential aged care facilities

<https://pubmed.ncbi.nlm.nih.gov/37924023/>

A systematic review of long-term care facility characteristics associated with COVID-19 outcomes

<https://pubmed.ncbi.nlm.nih.gov/34549415/>

Assessing infection prevention and control programs in residential aged care in Australia: A multi-methods cross-sectional study

<https://onlinelibrary.wiley.com/doi/10.1111/ggi.14791>

Have you been involved with a recent publication that would be of interest to the wider ACIPC community?

If so, we'd love to hear from you. Please contact the office at office@acipc.org.au



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