Infection Control Standards in Australian Aged Care Facilities

Rhonda L Stuart
What’s All The Fuss?

• The global population is aging
  – By 2050, 21.4% people are projected to be aged > 60 years
  – In Australia the number of people aged 85 and over projected to quadruple from 0.4 to 1.8 million by 2050

• 31% >85 years currently in Aged Care

• Estimated that 6% of population (1.4 million) will need NH or SAH accommodation by 2030

Van Duin. CID 2012
DOHA. 2011
Residential Aged Care

Functionally the home of the resident

• Types of care
  • RACF = LTCF = Nursing home
  • A diverse group of institutions that care for patients of all ages
  • Intensity of skilled care provided varies widely
  • Average resident is female > 80 years
  • Long term care for > 6 months
Differences to Acute Care

• Residents
  • Impaired communication
    » non-localizing symptoms
  • Comorbidities
    » chronic cognitive +/or physical impairments
  • Immune senescence
    » atypical clinical manifestations of infection
• Invasive devices, incontinence, impaired mobility
• Frequent antibiotic exposure
• High frequency of social contacts
  » enhancing cross transmission
Differences to Acute Care

• Lack of robust data and diagnostic testing
  • Access, timeliness
  • Interpretation
    » 90% inappropriate diagnostic work-up
• Radiology access
• Multiple laboratory providers
  » Samples rarely taken, result availability poor
  » Surveillance issues
• Multiple community pharmacies
  » DDDs unavailable

Loeb Infect Control Hosp Epidemiol 2000
Accreditation

“Internationally recognised evaluation process to assess the quality of care and services provided in a range of areas such as health care, long term residential aged care, disability services, and non-health related sectors such as child care

Part of a safety and quality framework.”
Accreditation

• Have both compliance and quality elements that work in a together to promote quality and safety.
• Focus on continuous quality improvement strategies.
• Consist of a process involving self-assessment, review or assessment of performance against predetermined standards by an external independent body, and monitoring of ongoing performance against the standards by the accreditation body.
Accreditation

• In Australia, residential aged care homes are required to be accredited to receive Australian Government subsidies.

• This involves periodic full audits, as well as unannounced visits to monitor continuing compliance with standards.
Currently 4 Standards

- Accreditation Standards
- Home Care Standards
- National Aboriginal and Torres Strait Islander Flexible Aged Care program Quality Framework Standards
- Transition care Standards
Changes

• The 4 standards do not reflect recent aged care reforms
• Make it difficult for consumers to understand what they should expect from providers
• Make regulation complex

Therefore a single set of standards is under development
Accreditation Standard 1

Management systems, staffing and organisational development

- **Principle:** Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of care recipients, their representatives, staff and stakeholders, and the changing environment in which the service operates.

- **1.1 Continuous improvement**
  - The organisation actively pursues continuous improvement.

- **1.2 Regulatory compliance**
  - The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.

- **1.3 Education and staff development**
  - Management and staff have appropriate knowledge and skills to perform their roles effectively.

- **1.4 Comments and complaints**
  - Each care recipient (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.

- **1.5 Planning and leadership**
  - The organisation has documented the residential care service’s vision, values, philosophy, objectives and commitment to quality throughout the service.

- **1.6 Human resource management**
  - There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service’s philosophy and objectives.

- **1.7 Inventory and equipment**
  - Stocks of appropriate goods and equipment for quality service delivery are available.

- **1.8 Information systems**
  - Effective information management systems are in place.

- **1.9 External services**
  - All externally sourced services are provided in a way that meets the residential care service’s needs and service quality goals.
Accreditation Standard 2

- Health and personal care
- 2.1 Continuous improvement
  The organisation actively pursues continuous improvement.
- 2.2 Regulatory compliance
  The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.
- 2.3 Education and staff development
  Management and staff have appropriate knowledge and skills to perform their roles effectively.
- 2.4 Clinical care
  Care recipients receive appropriate clinical care.
- 2.5 Specialised nursing care needs
  Care recipients’ specialised nursing care needs are identified and met by appropriately qualified nursing staff.
- 2.6 Other health and related services
  Care recipients are referred to appropriate health specialists in accordance with the care recipient’s needs and preferences.
- 2.7 Medication management
  Care recipients’ medication is managed safely and correctly.
- 2.8 Pain management
  All care recipients are as free as possible from pain.
- 2.9 Palliative care
  The comfort and dignity of terminally ill care recipients is maintained.
- 2.10 Nutrition and hydration
  Care recipients receive adequate nourishment and hydration.
- 2.11 Skin care
  Care recipients’ skin integrity is consistent with their general health.
- 2.12 Continence management
  Care recipients’ continence is managed effectively.
- 2.13 Behavioural management
  The needs of care recipients with challenging behaviours are managed effectively.
- 2.14 Mobility, dexterity and rehabilitation
  Optimum levels of mobility and dexterity are achieved for all care recipients.
- 2.15 Oral and dental care
  Care recipients’ oral and dental health is maintained.
- 2.16 Sensory loss
  Care recipients’ sensory losses are identified and managed effectively.
- 2.17 Sleep
  Care recipients are able to achieve natural sleep patterns.
Accreditation Standard 3

- **Care recipient lifestyle**
- **Principle:** Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.

- **3.1 Continuous improvement**
- The organisation actively pursues continuous improvement.

- **3.2 Regulatory compliance**
- The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about care recipient lifestyle.

- **3.3 Education and staff development**
- Management and staff have appropriate knowledge and skills to perform their roles effectively.

- **3.4 Emotional support**
- Each care recipient receives support in adjusting to life in the new environment and on an ongoing basis.

- **3.5 Independence**
- Care recipients are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.

- **3.6 Privacy and dignity**
- Each care recipient’s right to privacy, dignity and confidentiality is recognised and respected.

- **3.7 Leisure interests and activities**
- Care recipients are encouraged and supported to participate in a wide range of interests and activities of interest to them.

- **3.8 Cultural and spiritual life**
- Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.

- **3.9 Choice and decision-making**
- Each care recipient (or his or her representative) participates in decisions about the services the care recipient receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.

- **3.10 Care recipient security of tenure and responsibilities**
- Care recipients have secure tenure within the residential care service, and understand their rights and responsibilities.
Accreditation Standard 4

- Physical environment and safe systems
  - Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.
- 4.1 Continuous improvement
  - The organisation actively pursues continuous improvement.
- 4.2 Regulatory compliance
  - The organisation’s management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.
- 4.3 Education and staff development
  - Management and staff have appropriate knowledge and skills to perform their roles effectively.
- 4.4 Living environment
  - Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients’ care needs.
- 4.5 Occupational health and safety
  - Management is actively working to provide a safe working environment that meets regulatory requirements.
- 4.6 Fire, security and other emergencies
  - Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
- 4.7 Infection control
  - An effective infection control program.
- 4.8 Catering, cleaning and laundry services
  - Hospitality services are provided in a way that enhances care recipients’ quality of life and the staff’s working environment.
Expected outcome 4.7 Infection control

This expected outcome requires that there is:

*An effective infection control program.*

The focus of this expected outcome is ‘results’.

**Results**

- Management demonstrates its infection control program (plans, procedures, practices, equipment) is effective in identifying and containing infection.
- Management has information on infection or other data about the effectiveness of its infection control program in identifying, containing and preventing infection.
- Staff practice is consistent with Australian Government infection control guidelines.
- There is a food safety program in place.

**Processes**

*Consider:*

- Is there a central point of responsibility for the infection control program?
- Does the home have contingency plans for an outbreak (such as pandemic influenza or epidemic gastroenteritis)?
- How does the home access information on current community outbreaks and on how to control the spread of specific infections?
- How does the home ensure the effectiveness of risk assessments to identify potential sources of infection/cross infection?
- How does the home ensure the effectiveness of prevention strategies to minimise the incidence of infection in all areas of the home including processes and facilities for the implementation of standard precautions such as:
  - processes and facilities for hand-washing and use of personal protective equipment
  - processes and facilities for the provision of health and personal care services
  - a food safety program
  - processes and facilities for cleaning, disinfecting and sterilising equipment and laundry items
  - pest control measures
  - vaccination programs for residents and staff
  - the containment of sharps, contaminated waste and blood spills?
- How does the home ensure identification and management of each resident's specific infections? This includes assessment of residents' individual needs including their susceptibility to infections and evaluation of management strategies?
- How does the home provide appropriate induction and ongoing training for staff about the principles and practices of infection control?
- How does the home regularly monitor and review the effectiveness of its infection control program? For example, does the program include:
  - Infection surveillance which includes the collection and analysis of resident infection information
  - monitoring and review of staff practices including in relation to the use of assessment tools, equipment, and methods of facilitating an effective infection control program
  - Identification of Infection control issues
  - Implementation of Improved
Survey of infection control and antimicrobial stewardship practices in Australian residential aged-care facilities

R. L. Stuart,1,2 C. Marshall,3,4 E. Orr,1 N. Bennett,5 E. Athan,6,7 D. Friedman6,7 and M. Reilly,8 on behalf of Members of RACRIG (Residential Aged Care Research Interest Group)*

1Department of Infectious Diseases, Monash Health and 2Department Medicine, Monash University and 3Department of Infectious Diseases, Royal Melbourne Hospital and 4Department Medicine, University of Melbourne and 5VICNISS Coordinating Centre, Melbourne and 6Department Infectious Disease, Barwon Health and 7Department of Medicine, Deakin University, Geelong, Victoria and 8Hands-On Infection Control, Perth, Western Australia, Australia
Methods

• Utilised Commonwealth DoH database
• Identified RACF with > 50 beds
• Managers contacted by email/phone
• Survey completed online or hard copy and faxed back

• Approved by DoH Ethics Committee
The Survey

• 265/1700 survey completed (16%)
• Covering 22,350 beds (70% high care)
  • All States represented
  • Beds = 50 - 250
• Majority private facility
Results

- Male residents = 32%
- 63% > 85 years
- 3.5% urinary catheters in situ
- 0.1% vascular catheters in situ
- 4% in acute care facility in preceding 30 days
- 91% had dedicated infection control personnel
  - Only 31% had any certification in infection control
# Procedures and Surveillance

<table>
<thead>
<tr>
<th>Procedure Availability</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td>Management/isolation of MRSA carriers</td>
<td>226 (85.9)</td>
</tr>
<tr>
<td>Management/isolation of VRE carriers</td>
<td>206 (78.3)</td>
</tr>
<tr>
<td>Management/isolation of MDR-GN</td>
<td>174 (66.2)</td>
</tr>
<tr>
<td>Wound management</td>
<td>259 (98.5)</td>
</tr>
<tr>
<td>Management of urinary catheters</td>
<td>250 (95.1)</td>
</tr>
<tr>
<td>Management of vascular catheters</td>
<td>73 (27.8)</td>
</tr>
<tr>
<td>Management of enteral feeding</td>
<td>218 (82.9)</td>
</tr>
<tr>
<td>Standard precautions</td>
<td>253 (96.2)</td>
</tr>
<tr>
<td>Management/isolation of gastroenteritis</td>
<td>258 (98.1)</td>
</tr>
<tr>
<td>Management/isolation of <em>Clostridium difficile</em></td>
<td>156 (59.3)</td>
</tr>
<tr>
<td>Cleaning rooms of MRO carriers</td>
<td>228 (86.7)</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>256 (97.3)</td>
</tr>
<tr>
<td>Antibiotic use</td>
<td>106 (40.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Surveillance undertaken</th>
<th>n (%)</th>
</tr>
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<tbody>
<tr>
<td>Non-catheter-associated urinary tract infection</td>
<td>240 (92.7)</td>
</tr>
<tr>
<td>Catheter-associated urinary tract infection</td>
<td>211 (81.5)</td>
</tr>
<tr>
<td>Blood stream infection</td>
<td>171 (66)</td>
</tr>
<tr>
<td>Common cold/pharyngitis</td>
<td>195 (75.3)</td>
</tr>
<tr>
<td>Influenza-like illness</td>
<td>229 (88.4)</td>
</tr>
<tr>
<td>Lower respiratory tract infection/pneumonia</td>
<td>242 (93.4)</td>
</tr>
<tr>
<td>Skin and soft tissue infection</td>
<td>242 (93.4)</td>
</tr>
<tr>
<td>Skin condition, wounds and ulcers</td>
<td>251 (96.9)</td>
</tr>
<tr>
<td>Eye infection</td>
<td>250 (96.5)</td>
</tr>
<tr>
<td>Gastrointestinal infection</td>
<td>242 (93.4)</td>
</tr>
<tr>
<td><em>Clostridium difficile</em> infection</td>
<td>151 (58.3)</td>
</tr>
<tr>
<td>MRSA infection</td>
<td>197 (76.1)</td>
</tr>
<tr>
<td>VRE infection</td>
<td>182 (70.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Use of transmission based precautions where appropriate</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact (single room, gloves, gown)</td>
<td>239 (91.6)</td>
</tr>
<tr>
<td>Droplet (single room, surgical mask)</td>
<td>183 (70.1)</td>
</tr>
<tr>
<td>Airborne (negative pressure room, N95/P2 mask)</td>
<td>34 (13)</td>
</tr>
<tr>
<td>None</td>
<td>23 (8.8)</td>
</tr>
</tbody>
</table>
Hand Hygiene

- ABHR available in 95% of facilities
- ABHR available in 28% of resident bedrooms
- Education on HH available in all except 3 facilities
Antimicrobial Prescribing

• Prescribing GP led in 100%
  » 34% also had prescribing specialists
  » Notification:
    • Telephone – 98%
    • Communication book – 46%
    • Wait for GP to visit – 6%

• Policies for antimicrobial prescribing only available in 40% facilities
  » Only 14% had any prescribing restrictions

• Local pharmacies dispense medication in 86%
# Vaccinations

<table>
<thead>
<tr>
<th>Resident Vaccinations Available</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>245 (96.1)</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>170 (66.7)</td>
</tr>
<tr>
<td>Tetanus/diphtheria/pertussis</td>
<td>11 (4.3)</td>
</tr>
<tr>
<td>Varicella-zoster</td>
<td>6 (2.6)</td>
</tr>
<tr>
<td>No vaccines available</td>
<td>10 (3.9)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Vaccines Available</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>217 (86.5)</td>
</tr>
<tr>
<td>Tetanus/diphtheria/pertussis</td>
<td>21 (8.4)</td>
</tr>
<tr>
<td>Varicella-zoster</td>
<td>77 (30.7)</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>20 (8)</td>
</tr>
<tr>
<td>Measles/mumps/rubella</td>
<td>26 (10.4)</td>
</tr>
<tr>
<td>QuantiFeron® Gold/Mantoux testing</td>
<td>16 (6.4)</td>
</tr>
<tr>
<td>No vaccines available</td>
<td>31 (12.4)</td>
</tr>
</tbody>
</table>
Vaccinations

• Reported resident influenza vaccination rate in 2013
  – > 75% in 73% of facilities
  – 50 – 75% in 17% of facilities
  – < 50% in 11% of facilities

• Reported staff influenza vaccination rate in 2013
  – > 75% in 14% of facilities
  – 50 – 75% in 26% of facilities
  – < 50% in 60% of facilities
Vaccinations

- 67% facilities claimed to be able to provide pneumococcal vaccination to residents
- Only 20% reported vaccination rates > 75%
- 45% were unaware of pneumococcal vaccination status
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Examples</th>
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</table>
| **Align accreditation of RACF with National Standards for the Acute Sector** | Include a focus on  
  - Infection Prevention and Control  
  - Antimicrobial Stewardship  
  - Immunisation |
| **Develop database of policies and procedures for facilities to access** | Standardised procedures for managing  
  - MRSA colonisation  
  - VRE colonisation  
  - Management of urinary catheters  
  - Multidrug-resistant Gram negative colonisation  
  - *Clostridium difficile* infection  
  - Urinary catheters |
| **Develop antimicrobial guidelines for common infections in RACF** | Suggested  
  - Urinary sepsis with and without indwelling catheter  
  - Respiratory tract infection  
  - Skin and soft tissue infection |
| **Develop surveillance program for MDRO** | Include Australia wide focus on  
  - *Clostridium difficile*  
  - Multidrug-resistant Gram negative bacteria  
  - MRSA and VRE |
| **Enhanced Immunisation** | Increase vaccination rates  
  - Influenza – resident  
  - Influenza - healthcare workers  
  - Pneumococcal vaccine - residents |
| **Develop education packages for nursing staff** | Diploma opportunities  
  - Nurse practitioner role in RACF  
  - Infection control in RACF |
| **Hand hygiene** | Guideline development specific for RACF |
| **Cleaning and disinfection** | Guideline development specific for RACF |
# Incidence of infection

<table>
<thead>
<tr>
<th></th>
<th>Nicolle 1996</th>
<th>Stevenson 2005</th>
<th>Lim 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory tract</td>
<td>0.46 - 4.4</td>
<td>1.75 (0.68, 2.88)</td>
<td>1.12 (1.0, 1.25)</td>
</tr>
<tr>
<td>Urinary tract</td>
<td>0.1 - 2.4</td>
<td>0.6 (0.16, 1.01)</td>
<td>1.53 (1.39, 1.69)</td>
</tr>
<tr>
<td>Skin/soft tissue</td>
<td>&lt;0.1 - 2.1</td>
<td>1.11 (0.68, 2.37)</td>
<td>0.61 (0.52, 0.71)</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>0 - 0.9</td>
<td>0.16 (0, 0.43)</td>
<td>0.15 (0.11, 0.21)</td>
</tr>
</tbody>
</table>

Rate per 1000 patient days

- Variation in rates due to:
  - Institutional population
  - Case finding methods
  - Diagnostic uncertainty
  - Surveillance
  - ? Rates of MRGN
Prevalence of antimicrobial-resistant organisms in residential aged care facilities

Abstract

Antibiotic surveillance showed that during the 15 months before the study commenced, residents in the facilities studied received antibiotics for 445 episodes, 44% of which did not fulfil the criteria for bacterial infection.

With varying severity, from mild diarrhoea to pseudomembranous colitis, toxic megacolon or death. Since 2000, there has been an increase in the rates of C. difficile infection in health care facilities in the United States and Europe associated with an epidemic strain, PCR ribotype 027, characterised...
Antibiotic Usage at Chestnut Gardens 2015 -

- No. prescribed antibiotics
- No. not fitting criteria
Management of MROs
# Risk Factors for Health Care–Associated MROs

<table>
<thead>
<tr>
<th>Table 1. Risk Factors for Health Care–Associated Infections and Infection with Drug-Resistant Bacteria.¹⁵</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk factors for health care–associated infections</strong></td>
</tr>
<tr>
<td>Hospitalization for ≥2 days in preceding 90 days</td>
</tr>
<tr>
<td>Residence in a nursing home or long-term care facility</td>
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<tr>
<td>Home infusion therapy, including antimicrobial agents</td>
</tr>
<tr>
<td>Long-term dialysis within 30 days</td>
</tr>
<tr>
<td>Home wound care</td>
</tr>
<tr>
<td>Family member with multidrug-resistant pathogen</td>
</tr>
<tr>
<td><strong>Risk factors for infection with drug-resistant bacteria</strong></td>
</tr>
<tr>
<td>Antimicrobial therapy in preceding 90 days</td>
</tr>
<tr>
<td>Current hospitalization for ≥5 days</td>
</tr>
<tr>
<td>High frequency of antibiotic resistance in the community or in the specific hospital unit</td>
</tr>
<tr>
<td>Immunosuppression</td>
</tr>
</tbody>
</table>

* Risk factors are from the Infectious Diseases Society of America and the American Thoracic Society guidelines.¹⁵

Potential strategies

1. Staff hand hygiene
2. Resident hand hygiene
3. Clinical care- protect skin, avoid trauma, avoid unnecessary urinary catheter use
4. Judicious use of antibiotics
5. Staffing levels, education and competency
6. Environment and equipment cleaning and disinfection
7. Risk management approaches
8. Active screening/isolation/ decolonisation of residents
Carbapenemase-producing Enterobacteriaceae

For Long-term residential care facilities

Version 1

November 2016
RACF and AMS

- Antimicrobial prescribing
  - 47-79% residents receive antimicrobials annually

- Variation to prescribing
  - Prescriber dependent rather than recipient driven

- Many (up to 75%) prescriptions are:
  - Inappropriate, unnecessary, prolonged

- Harm seen for ALL residents in high prescribing facilities
  - Damage goes beyond the individual

Van Buul. JAMDA 2013
RACF and AMS

• Substantial inappropriate use
  • 40 – 70%

• Negative outcomes
  • Antimicrobial resistance
  • Diarrhea/Clostridium difficile
  • Allergy
  • Cost
  • Toxicity/Interactions
  • Direct and indirect effects

Van Buul. JAMDA 2013
The Core Elements of Antibiotic Stewardship for Nursing Homes
Summary of *The Core Elements of Antibiotic Stewardship for Nursing Homes*

- **Leadership commitment**
  Demonstrate support and commitment to safe and appropriate antibiotic use in your facility.

- **Accountability**
  Identify physician, nursing, and pharmacy leads responsible for promoting and overseeing antibiotic stewardship activities in your facility.

- **Drug expertise**
  Establish access to consultant pharmacists or other individuals with experience or training in antibiotic stewardship for your facility.

- **Action**
  Implement at least one policy or practice to improve antibiotic use.

- **Tracking**
  Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use in your facility.

- **Reporting**
  Provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff, and other relevant staff.

- **Education**
  Provide resources to clinicians, nursing staff, residents, and families about antibiotic resistance and opportunities for improving antibiotic use.

Source: Reproduced from *The Core Elements of Antibiotic Stewardship for Nursing Homes* published by the Centers for Disease Control and Prevention
Unnecessary prescribing of antimicrobials leads to antimicrobial resistance

A recent study in 186 Australian residential aged care facilities highlighted:

- 65% no documented review or stop date
- 65% of the antimicrobial prescriptions did not have a review or stop date written in the notes.
- 32% no documented reason
- In 32% of cases, the reason for the antimicrobial prescription was not written in the notes.
- 18% unspecified skin infections
- The most common reason (18%) for antimicrobial prescriptions was unspecified skin infections.
- 20% no infection signs or symptoms
- Approximately 1 in 5 antimicrobial prescriptions were prescribed for residents who did not have any signs and symptoms of infection.
- 31% prescribed over 6 months
- 31% of the antimicrobial prescriptions were prescribed for greater than six months. Of these, 10% did not have a review or stop date documented.

Improve antimicrobial prescribing in your residential aged care facility

To better understand your prescribing patterns, implement an antimicrobial stewardship program today!

Learn more about antimicrobial use and resistance at www.safetyandquality.gov.au
Participate in the aged care National Antimicrobial Prescribing survey at www.naps.org.au
• 251 (up from 186) aged care facilities participated.
• Most common reason (17.9%) for prescriptions was for UTIs (previously skin and soft tissue higher)
• 22.1% (down from 32%) of prescriptions did not have the indication documented.
• 49.9% (down from 65%) of prescriptions did not have a review or stop date documented.
• 23.3% (down from 31%) of antimicrobial prescriptions were prescribed for >6 months.
Revised Standards

• Currently working with the sector to develop a Single Quality Framework for aged care which will include one set of quality standards across all aged care.
• Public consultation on a draft single set of standards will occur in 2017.
• ? elements
Thank you