confirmed C. difficile in stool samples. To determine whether this was a common source nosocomial outbreak of C. difficile the samples were sent for toxigenic C. difficile culture and WGS.

Results: Three isolates were reported as ribotype ce416 belonging to the same sequence type, ST176. Another isolate was reported as ribotype ce417 and the 5th isolate was an unrelated ribotype (RT014). This sample did not undergo further analysis with WGS. Outbreak control measures were successful and no further patients developed diarrhoea. WGS revealed the ST 176 sequences were related, but not clonal, dispelling concerns about person-to-person transmission of C. difficile in this cluster of hospital-onset diarrhoea.

Conclusions: The use of WGS provided reassurance to the IPaC team and the hospital executive that there was no ongoing increased C. difficile infection risk to patients admitted to this ward.

47. ANTIMICROBIAL STEWARDSHIP QUALITY IMPROVEMENT IN 12 RESIDENTIAL AGED CARE FACILITIES: IMPLEMENTATION OUTCOMES OF “TO DIP OR NOT TO DIP”

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“[To Dip or Not to Dip] (TDONTD) is a quality improvement initiative focussed on educating clinical staff in residential aged care facilities (RACFs) to better recognise urinary tract infections (UTI) and asymptomatic bacteriuria (ASB); discouraging urinalysis as a practice that contributes to antibiotic overuse. An evaluation of the feasibility, useability and effectiveness of TDONTD using a mixed-methods approach was undertaken.

Methods: Implementation of education and clinical pathway was led by RACF nurses (“Champions”), supported by Quality Use of Medicines (QUM) pharmacists. Twelve Champions and four pharmacists participated in baseline and 3-month post-implementation activities.

Results: In baseline audits, 85 of 1,074 residents (7.9%) were on an oral antibiotic. Of oral antibiotics prescribed, 37.6% (32/85) were for a urinary tract indication. In baseline surveys, 50% of Champions reported that their facility did not use a protocol when assessing residents for UTI; 92% always or sometimes performed urinalysis after resident completion of antibiotic treatment. 25% said that urinalysis was regularly performed in asymptomatic residents.

Nearly all RACFs experienced outbreaks and many had changes to Champion roles. Case-based education was delivered by pharmacists in 11 of 12 facilities. Over November 2021 to April 2022, the clinical pathway was implemented in 9 of 12. We will discuss 3-month survey, interview and audit results.

Conclusion: UTI is a common reason for antibiotic prescribing in RACFs. TDONTD is a nurse-led AMS implementation activity to improve UTI recognition in RACFs. We will describe the feasibility, useability and effectiveness of TDONTD delivered by AMS Champions supported by QUM Pharmacists.

53. TOWARDS OPTIMAL QUARANTINE: A SCOPING REVIEW OF QUARANTINE PLANNING IN THE PANDEMIC PREPAREDNESS PLANS AND PANDEMIC EXERCISES OF AUSTRALIA AND NEW ZEALAND

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Introduction: Since 2020, the New Zealand and Australian federal, state and territory governments have used quarantine as a strategic infection control measure to contain the SARS-CoV-2 (COVID-19) virus. However, the quarantine programs of both countries were rapidly operationalised without a clear blueprint for infection prevention. This paper identifies gaps in forecasting the need, and planning, for widespread quarantine within New Zealand’s and Australia’s Pandemic Preparedness Plans and pandemic exercise reports.

Methods: This paper adhered to the Joanna Briggs Institute (JBI) methodology for scoping reviews. Parliamentary websites and databases (Parlinfo, Pandora) were searched for plans and exercise reports, that were publicly available from 2009 to May 2022. Documents were examined using directive content analysis and assessed on their alignment with the core elements of people, resources, governance, systems, and processes, as addressed in the Australian Disaster Preparedness Framework 2018. The degree to which the core elements outlined in the Australian Disaster Preparedness Framework were covered in the documents varies significantly across both New Zealand, and the Australian federal, states and territories. Of the 15 identified plans and 8 exercise reports most did not foresee the need for mandatory, large-scale quarantine of people arriving from interstate or overseas and contemplated voluntary quarantine occurring within people’s private residences.

Conclusion: This paper confirms the need to focus on widespread quarantine as an infection control measure to enhance future pandemic operational preparedness. Further development of quarantine capabilities is required in
locations aside from private residences, including at Australia’s new purpose-built quarantine facilities.

58. STATEWIDE COVID-19 HOSPITALISED PATIENT SURVEILLANCE DEVELOPMENT AND ENHANCEMENT

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Introduction: With onset of the first COVID-19 wave in March 2020, the Victorian Department of Health (DH) engaged the Victorian Healthcare Associated Infection Surveillance System Coordinating Centre (VICNISS) to develop a system to monitor hospital patients with COVID-19. We describe the development and evolution of this program.

Methods: A secure on-line reporting module was created using the VICNISS platform. Standardised data specifications and definitions were established to monitor hospitalised patients, including: demographics, COVID-19 status at time of admission, daily location, ICU admission and ventilation status. Hospital users were registered and provided with educational/helpline support. Hospitals and DH were able to generate real-time reports. VICNISS followed up data discrepancies, queries and/or failure to report.

Results: Weekly validation was introduced in June 2020 to confirm all hospitalised COVID cases had been reported. Upon DH request, VICNISS undertook a look-back in September 2020 to identify hospital-acquired COVID-19 infections. Historical COVID-19 episodes were reviewed and classified according to internationally-accepted definitions. In early 2021, an algorithm using these definitions was applied prospectively to inform hospitals immediately if a submitted COVID-19 case was hospital-acquired. COVID-19 vaccination status was further added to data submission in April 2021, in order to inform policy.

Conclusion: A system that successfully captures data to inform Victoria’s COVID-19 case management capacity was rapidly deployed by leveraging the existing platform used by hospitals for infection prevention and control surveillance activities. Post-implementation enhancements improved efficiencies and timeliness of reporting to support responses and risk mitigation within Victorian facilities.

60. TRANSFORMING THE WAY WE THINK ABOUT INFECTION PREVENTION AND CONTROL - IT’S TIME TO CHALLENGE THE BIOMEDICAL RHETORIC

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Introduction: Infection prevention and control (IPC) came to the fore during the COVID-19 pandemic with global expectations in healthcare of compliance with recognised international guidelines. Yet despite 40 years of modern IPC practice, health services around the world struggle to maintain minimal IPC standards even without the pressures of a pandemic, many are in resource-limited settings. Atoll Adventist Hospital (AAH) in the Solomon Islands is one such hospital.

Aim: To investigate IPC practice at AAH with the aim of creating a meaningful and sustainable program. In doing this, staff and community knowledge and beliefs about infection transmission was explored, and IPC practice and rationale determined.

Methods: This qualitative study employed a participatory action research methodology using Photovoice followed by semi-structured interviews as the primary data collection method. Participants included staff educated in biomedical principles, and staff with little or no formal education.

Results: Improving IPC practice is not straightforward. Cultural, spiritual and societal practices and beliefs influence how people view disease causation and transmission and affects healthcare worker’s practice. ‘Germ theory’ does not necessarily inform people’s beliefs, even for staff educated via the biomedical model; to implement IPC guidelines based on germ theory principles, and expect staff to practise accordingly, is not plausible.

Conclusion: IPC programs will only work if they are transformed into a context that is understood by staff and community - one that complements the biomedical model. Governments and hospital leaders need to consider this when implementing IPC programs. It’s time for us to challenge the rhetoric.

62. THE NATIONAL INFECTION SURVEILLANCE PROGRAM FOR AGED CARE (NISPAC): A COLLABORATIVE SYSTEMS APPROACH TO PROGRAM DEVELOPMENT, IMPLEMENTATION AND EVALUATION

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Introduction: Residents of residential aged care facilities (RACFs) are vulnerable to infections, many of which are preventable. Infection and antimicrobial use surveillance programs are therefore a vital part of infection prevention and control (IPC) activities for Australian RACFs and support quality and safety systems for residents, staff and visitors. In Australia, there is currently no nationally coordinated surveillance program. We aim to develop a National Infection Surveillance Program for Aged Care (NISPAC), which will streamline and standardise surveillance methodology and enable national benchmarking.

Method: Three peak bodies - the Victorian Healthcare Associated Infection Surveillance System (VICNISS), the National Centre for Antimicrobial Stewardship (NCAS) and the Registry for Senior Australians (ROSA) - have collaborated to endorse a staged investigation, development and implementation framework for the establishment of NISPAC.

Results: The investigation stage involves qualitative interviews with surveillance staff, a survey of RACF staff, document analysis and data linkage to understand existing surveillance programs. The development stage will use results from these methods, along with focus groups and user testing by RACF staff, and expert consultation to develop NISPAC. Finally, the program will be trialled in a representative sample of RACFs. Across these stages, the framework draws on the Centre for Disease Control and Prevention guidelines for evaluating public health surveillance systems, the Theoretical Framework and co-design principles.

Conclusion: A systematic and comprehensive framework for development, implementation and evaluation of NISPAC will support the establishment of a robust and integrated national program.

63. PATIENT SAFETY COMES FIRST THROUGH IMPLEMENTING RIGOROUS INFECTION PREVENTION STANDARDS WHEN USING ENDOCAVITY PROBES FOR ULTRASOUNOGRAPHY

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Introduction: Clinicians Need To assure proper cleaning and disinfection of endocavity ultrasound probes to prevent patient infection. Ultrasonography constitutes an integral part of modern patient care. Now with a broader cross-section of specialists that includes radiologists, obstetricians, gynecologists, urologists and emergency physicians.