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 lookback 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.