



Australian Government
Australian Aged Care Quality Agency

Review of infection control practices in residential aged care in Australia

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Abbreviations

ACT	Australian Capital Territory
Care recipients	Residents of Residential Aged Care Services
CDNA	Communicable Diseases Network Australia
CEO	Chief Executive Officer
DON	Director of Nursing
GP	General Practitioner
NA	Not Applicable
NSW	New South Wales
NT	Northern Territory
OHP	Office of Health Protection
PHU	Public Health Unit
QLD	Queensland
Quality Agency	Australian Aged Care Quality Agency
RACS or Services	Residential Aged Care Services
SA	South Australia

Executive summary

Introduction

During influenza seasons, the elderly and people with chronic diseases are more at risk from influenza than the general population. In 2017, there was a high number of influenza cases in the community and an increased number of influenza deaths reported in residential aged care services (RACS).¹ Annual influenza vaccination is recommended for residents of aged care services (care recipients) due to high rates of influenza transmission and influenza-related complications during outbreaks in such facilities.^{2, 3} Vaccination of staff is also recommended to protect staff from influenza and to reduce transmission to care recipients. RACS should aim for at least 95% of all staff and care recipients to be vaccinated prior to the beginning of each influenza season.³

The national survey

From 27 October 2017 to 2 January 2018, the Australian Aged Care Quality Agency (the Quality Agency) undertook a nationwide online survey of RACS to review infection control practices, influenza vaccine administration and influenza and gastrointestinal outbreak management procedures. The aim was to understand current practice and to identify ways to better prevent and manage disease outbreaks in RACS. The survey was designed in consultation with the Office of Health Protection (OHP), Department of Health.

The *Aged Care Act 1997* requires the providers of Commonwealth-funded RACS in Australia to comply with the Accreditation Standards which include a requirement for RACS to have an effective infection control program. The Quality Agency undertook this national survey of accredited RACS under its function to monitor compliance with these standards. A total of 2609 RACS from all over Australia took part in the survey. The link to the survey was sent to 2704 aged care services and 2609 responses were received (response rate 96.5%).

What we found

The major findings of this report are:

- 97.9% of RACS reported having an infection control plan/program.

- 96.6% of RACS reported having an annual influenza vaccination program for their workforce. However, the great majority (90.1%) of services stated that participation was not mandatory.
- 96.5% of RACS reported having an annual influenza vaccination program in place for care recipients.
- Proportions of RACS achieving a vaccination rate $\geq 95\%$ among staff, agency staff and volunteers were 3.5% (73/2089), 8.6% (50/577) and 19.0% (124/652), respectively.
- The proportion of RACS achieving a vaccination rate $\geq 95\%$ among care recipients was higher at 35.9% (852/2372).
- The proportion of RACS reporting at least one influenza outbreak during the previous 12 months was 43%.
- In RACS with staff vaccination rates of $>75\%$, the proportion reporting at least one influenza outbreak (39.3%) was significantly lower than in those with staff vaccination rates of $<25\%$ (48.6%).
- RACS that reported providing access to influenza vaccine under their programs had higher rates of staff vaccination as compared with those who only encouraged staff to go to an external immunisation provider.
- Having a documented infection control plan and documentation of staff influenza vaccine receipt both were associated with improved vaccination rates among care recipients, staff agency, staff and volunteers.

Summary of findings by topic area

1. Infection control plans

The majority of the respondents (97.9%; n=2553) reported having an infection control plan for influenza and other respiratory viruses, of which 2295 (90%) reported reviewing the plan annually. Similar findings were observed for infection control plans for gastroenteritis. There was no significant difference in the proportion of RACS reporting influenza outbreaks that had an infection control plan compared with those that did not (44.9% versus 39.3%; $X^2=0.67$; p=0.49).

2. Influenza vaccination

Most respondents (96.5%; n=2518) reported having an annual influenza vaccination program for care recipients. However, participation was not mandatory in almost all

services (92.1%; n=2318). In 73% of RACS (n=1905), it was reported that access to the vaccine was provided for care recipients; in 18.4% of services, residents were asked to obtain the vaccine from an external provider (e.g. a GP). Around one third of RACS reported vaccination coverage of $\geq 95\%$ for care recipients (35.9%; 852/2372). The proportion reporting vaccine uptake in care recipients of at least 50% was 94.6% (2245/2372). Uptake of influenza vaccine among care recipients was higher in RACS that reported providing access to the vaccine compared with the uptake in those where care recipients obtained it from an external provider only.

The majority of RACS (96.6%; n=2521) reported having an annual influenza vaccination program for their workforce. However, this was not mandatory in most (90.1%). Most RACS (86.3%; n=2253) indicated that they provided access to influenza vaccination for their staff. Some (9.6%) reported that their program consisted only of encouraging staff to get the vaccine from external providers such as GPs. The proportion of RACS achieving coverage rates of $\geq 95\%$ in their workforce was low: 3.5% of services for staff (73/2089), 8.6% of services for agency staff (50/577) and 19% of services for volunteers (124/652). The proportion of RACS that reported vaccine coverage of $\geq 50\%$ in staff was 45.2% (945/2089). Uptake of influenza vaccine among workforce was higher in RACS that provided access to the vaccine at the service.

Most RACS reported that they maintained a current register of influenza vaccination records for care recipients (85.8%) and staff (79.3%), but fewer reported maintaining a register for agency staff (3.1%) or volunteers (20.7%). In some services (7.4%), no register was kept for any category (staff, care recipients or volunteers).

3. Influenza and gastroenteritis outbreaks

The occurrence of a potential influenza outbreak/s in the past 12 months was reported by 1167 (44.7%) of services. Reported outbreaks affected both care recipients (n=1152 services) and staff (n=959 services). Most outbreaks affected fewer than 20 individuals, but larger outbreaks (affecting ≥ 20 individuals) occurred among care recipients in 215 services. For RACS with influenza vaccination rates of $\geq 75\%$ for staff, there was a trend towards fewer reported influenza outbreaks (39.3%; 156/397) compared with RACS where the staff vaccination rate was $< 75\%$ ($X^2 = 27.2$; $p < 0.01$). Occurrence of a gastroenteritis outbreak/s that affected both care recipients and staff was reported by 30.5% of services.

Influenza or gastroenteritis outbreaks associated with deaths of care recipients were reported by 302 RACS (11.6%). The number of fatalities ranged from 1 to 18. All but three reported outbreaks were associated with fewer than 10 deaths (range 1–8); three services reported between 10 and 20 deaths (12, 14 and 18 deaths, respectively). RACS were not asked in the survey to differentiate between deaths from influenza and gastroenteritis; thus, any potential association between influenza vaccination rates and influenza-related deaths could not be analysed. Most RACS (61.2%) stated that all outbreaks in the preceding 12 months had been reported to the state/territory health department; a small proportion (2.4%) of RACS stated that they did not report outbreaks; and 3.3% did not maintain an outbreak register.

4. Documenting and reporting

Over 95% of RACS stated that they had various infection control/outbreak response processes in place. However, among these processes, fewer services (89.1%) reported review of care recipients' temperature monitoring charts as routine. When asked how the respondents rated their infection control management, 52.4% considered that they followed best practice, 45% rated themselves as satisfactory and only 2.6% thought they needed improvement.

5. Staff training

RACS that provided staff training on the use of the outbreak kit for influenza were more likely to report outbreaks to the state/territory health departments (64.3% versus 47.6%; $X^2= 45.6$; $p<0.01$). Similar findings were observed for gastrointestinal outbreaks and staff training.

Conclusions

This nationwide survey provides self-reported data on infection control practices, influenza vaccine administration and influenza and gastrointestinal disease outbreaks in RACS. The intent of the survey was to build a baseline picture of infection prevention and control practices in RACS. These self-reported practices and associations were thus preliminary, and can only be used as a starting point for further investigation, not as proof of any association. Information from this survey provides insights into current practice and potential ways to better explore avenues for the prevention and management of influenza and gastrointestinal disease in these services.

Introduction

In Australia, people aged 65 years and older represent 15% of the population but account for 80% of deaths.⁴ In 2017, a large number of deaths associated with influenza were reported, consistent with the high number of influenza cases in the community.¹ Although accurate assessment of the mortality rates associated with influenza is challenging and deaths underreported, of the 746 influenza associated deaths recorded in 2017, more than 91% of deaths were in people aged 65 years and older.¹ The most common influenza virus that circulated in 2017 was influenza A(H3N2); elderly people are more susceptible to this strain of virus.¹

Influenza vaccine prevents or attenuates influenza infection and prevents mortality.² New influenza vaccines are formulated each year based on the strains of virus predicted to predominate in the coming influenza season.⁵ Influenza vaccine has been shown to reduce the risk of hospitalisation from influenza and to reduce mortality in care recipients aged 65 years and older.^{3, 6}

The *Australian Immunisation Handbook* recommends annual influenza vaccination for residents of aged care services due to high rates of influenza transmission and influenza-related complications during outbreaks in such services.² In addition, Guidelines for the Prevention, Control and Public Health Management of Influenza Outbreaks in Residential Care Services in Australia published by the Communicable Diseases Network of Australia (CDNA) recommend that RACS actively promote annual influenza vaccination for all care recipients, staff and volunteers, and vaccination coverage of 95% or more in care recipients and staff.³ Family members of care recipients and regular visitors to RACS should also be encouraged to have the recommended current annual influenza vaccine.³ A further recommendation is that a vaccination register systematically record the vaccination status of all care recipients and staff each year, prior to the beginning of influenza season.³ In addition, all RACS should operate in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.⁷

Following the 2017 influenza season and investigations into the deaths of elderly residents at two residential care services,^{8, 9} the Quality Agency¹⁰ implemented a nationwide online survey of RACS to seek information about infection control practices, influenza vaccination rates and influenza and gastroenteritis outbreak management procedures.

Methods

The online survey (<https://www.aacqa.gov.au/providers/survey-tools/infection-control-survey>) was designed in consultation with the Office of Health Protection (OHP),

Department of Health and covered:

- vaccination rates for workforce (staff, agency staff and volunteers) and care recipients
- infection control planning, management and review
- monitoring and reporting of influenza and gastroenteritis outbreaks
- training in relation to infection control and outbreak management.

The first part of the survey questionnaire collected information on demographics of RACS that included service name, postcode, name of approved provider, designation of the person filling the questionnaire, number of care recipients, number of (regular or agency) staff and number of volunteers. The next part of questionnaire comprised questions on infection control policies in RACS, including influenza vaccination requirements, occurrence of influenza and gastrointestinal outbreaks, fatalities associated with influenza-like illness or gastroenteritis, and monitoring and reporting strategies.

Most questions were closed-ended. However, the design of the survey allowed participants to answer any subsequent related question, even if they answered 'no' to the lead question; this affected total response numbers in some cases. There was no scope for leaving any question unanswered; submission required a response to all questions.

The survey was implemented on 27 October 2017 and closed on 2 January 2018. The link to the survey was sent to 2704 RACS nationwide.

Statistical analysis

Descriptive analysis of the online survey was undertaken. Number and percentages of events, χ^2 (chi-square) and p values were calculated using SPSS version 22. For calculation of chi-square statistics from 2 by 2 tables, Yates correction for continuity was applied.

Results

The survey was sent to 2704 RACS in all states and territories (**Table 1**), and 2609 responses were received (response rate 96.5%). In most cases (89.5%), a senior

executive (e.g. a manager, director or nursing director) of the service responded to the survey (**Table 2**). The number of allocated care recipient places in the services ranged from 1 to 475 (mean 75.5, median 67) per service. The number of staff in each service was recorded as ranging from 0 to 690 (mean 92, median 83) and the number of volunteers in each service ranged from 0 to 294 (mean 13.8, median 7).

Table 1. Distribution of participating services across Australia (n=2609)

State and territory	Number of services (%)
NSW	855 (32.8)
Victoria	738 (28.3)
QLD	437 (16.7)
SA	243 (9.3)
WA	227 (8.7)
Tasmania	72 (2.8)
ACT	26 (1)
NT	11 (0.4)
Remoteness	
Inner regional	624 (23.9)
Major cities	1616 (61.9)
Outer regional	325 (12.5)
Remote	30 (1.1)
Very remote	14 (0.5)

Table 2. Distribution of respondents by their positions (n=2609)

Position of respondents	Number (%)
Manager	1755 (67.3)
Director	395 (15.1)
CEO	107 (4.1)
DON	78 (3)
Risk, Quality & Compliance Manager	75 (2.9)
Infection Control Coordinator	68 (2.6)
Clinical Nurse	39 (1.5)
Care Coordinator	33 (1.3)
Regional Manager	13 (0.5)
Head of Care	11 (0.4)
Not correctly identified	8 (0.3)
Others (supervisor, consultant, state general manager)	27 (1)

1. Governance

Infection control governance and planning is essential to ensure RACS are taking preventive measures and are well prepared to manage an influenza or gastroenteritis outbreak. Easily accessible internal policies and an outbreak management plan along with systematic methods for detecting and recording care residents who develop symptoms are key components.³

Majority of the respondents (97.9%; n=2553) reported having an infection control plan for influenza and other respiratory viruses; 56 (2.1%) declared they did not have a plan (**Table 3**). Of those that had an infection control plan for influenza and other respiratory viruses, 88% (2295 of 2609) reported reviewing their plan yearly and 9.2% (241/2609) reported no annual review.

Similarly, almost all respondents (99.7%; n=2600) reported having an infection control plan for gastroenteritis, and a similar proportion (87.3%; 2278 of 2609) reported annual review.

Table 3. Number of services with infection control plans (n=2609)

	Yes n (%)	No n (%)	Not applicable n (%)
Does the service have an infection control plan for influenza and other respiratory viruses?	2553 (97.9)	56 (2.1)	–
• If Yes, was it reviewed in the last 12 months?*	2295 (88)	241(9.2)	73 (2.8)
Does the service have an infection control plan for gastroenteritis?	2600 (99.7)	9 (0.3)	–
• If Yes, was it reviewed in the last 12 months?**	2278 (87.3)	277 (10.6)	54 (2.1)

*These numbers do not add to 2553 (number of service providers answering 'yes' in the previous question on whether or not having an infection control plan for influenza and other respiratory viruses).

**These numbers do not add to 2600 (number of service providers answering 'yes' in the previous question on whether or not having an infection control plan for gastroenteritis).

2. Immunisation

Vaccination is the most effective tool for preventing influenza. Seasonal vaccination programs for staff and residents of a RACS should aim for at least 95% vaccination rates before the beginning of an influenza season.³

Regarding seasonal influenza vaccination programs for staff, 96.6% (n=2521) of respondents reported that they had an annual influenza vaccination program for their workforce. However, in 90.1% services participation was not mandatory. In 86.3% (2253/2609) of RACS, access to influenza vaccine was provided to staff. A subset of these RACS (973) also encouraged staff to get the vaccine from external providers such as GPs. Some RACS (9.6%) only encouraged to get the vaccine from external providers. Most RACS (76.5%; n=1995) stated that their vaccination policy covered all staff. The proportions of RACS who nominated that their policy applied to staff in other categories were lower (ranging from 4.5% to 20.3% depending on occupational category), as shown in **Table 4**.

Table 4. Immunisation of staff in RACS (n=2609)

	Yes n (%)	No n (%)	Not applicable n (%)
Does the service have an annual influenza vaccination program for the workforce?	2521 (96.6)	88 (3.4)	–
If ‘yes’ is participation in the annual influenza program mandatory?*	173 (6.6)	2352 (90.1)	84 (3.2)
If ‘yes’ (the service has an annual influenza program for the workforce)			
• Provided access to influenza vaccination for staff	1280 (46.3)	–	–
• Provided access to influenza vaccination for staff and encouraged staff to go to an external provider	973 (37.3)	–	–
• Encourages staff to go to an external provider (e.g.GP) only	250 (9.6)	–	–
• Not applicable	106 (4.1)	–	–
Does the service have a policy about vaccination for the following staff**			
• All staff	1995 (76.5)	–	–
• Nurse practitioners	117 (4.5)	–	–
• Registered nurses	529 (20.3)	–	–
• Enrolled nurses	451 (17.3)	–	–
• Personal care attendants	512 (19.6)	–	–
• Allied Health professionals	285 (10.9)	–	–

• Allied Health assistants	233 (8.9)	–	–
• Management	510 (19.5)	–	–
• Administration	495 (19)	–	–
• Spiritual/pastoral care	189 (7.2)	–	–
• Ancillary care	210 (8)	–	–
• Maintenance and cleaning	496 (19)	–	–
• Catering and food preparation	485 (18.6)	–	–
• Volunteers	310 (11.9)	–	–
• None of the above	416 (15.9)	–	–

*These numbers when added exceed 2521 (number of service providers answering 'yes' in the previous question on whether or not having an annual influenza vaccination program for the workforce).

**Not mutually exclusive; services were asked to check all categories of staff that policy applied to.

Regarding influenza vaccination of care recipients, 96.5% (n=2518) of respondents reported having an annual program in place. However, participation in the program was mandatory in only 7.6% (n=197) of the services. In 73% (n=1905) of services, the vaccine was offered to care recipients and in 18.4% cases they were asked to go to an external provider (e.g. GP) to receive the vaccine (**Table 5**).

Table 5. Immunisation of care recipients in RACS (n=2609)

	Yes	No	NA
	n (%)	n (%)	n (%)
Does the service have an annual influenza program for care recipients?	2518 (96.5)	91 (3.5)	–
Is participation in the annual influenza program mandatory?*	197 (7.6)	2318 (88.8)	94 (3.6)
If Yes (service has an annual influenza program for care recipients)*			
• Provide access to influenza vaccination for care recipients	1905 (73)	–	–
• Encourage care recipients to go to an external provider (e.g.GP)	480 (18.4)	–	–
• None of the above	20 (0.8)	–	–
• Not applicable	204 (7.8)	–	–

*These numbers do not add to 2518 (number of service providers answering 'yes' in the previous question on whether or not having an annual influenza vaccination program for care recipients).

3. Monitoring and reporting

A vaccination register should systematically record the status of all care recipients and staff each year before the beginning of influenza season.³

When asked if the service maintained a current register of influenza vaccination records, 79.3% reported maintaining such a register for staff, 3.1% for agency staff, 20.7% for volunteers and 85.8% for care recipients. In 7.4% of services, no register of vaccination records was kept (for staff, care recipients or volunteers) (**Table 6**).

Table 6. Current register of influenza vaccination records in RACS (n=2609)

	Yes n (%)
Does the service maintain a current register of influenza vaccination records for the following:	
• Staff*	2070 (79.3)
• Agency staff*	82 (3.1)
• Volunteers*	539 (20.7)
• Care recipients*	2238 (85.8)
• No register kept	192 (7.4)

*Not mutually exclusive

When asked if the staff, care recipients or volunteers needed to provide evidence (documentation/receipt) of influenza vaccination, 96.9% reported that documentation was provided by agency staff, 84% by volunteers, 75.9% by care recipients and 69.4% by staff. Around 9% respondents reported that no evidence was required and 7.7% reported not keeping a register (**Table 7**).

Table 7. Evidence of vaccination in the current register of influenza vaccination records in RACS (n=2609)

	Yes n (%)
Do the following provide evidence of their vaccination (e.g. documentation or receipt)?	
• Staff*	1810 (69.4)
• Agency staff*	2528 (96.9)
• Volunteers*	2192 (84)
• Care recipients*	1979 (75.9)
• No evidence required	232 (8.9)
• No register kept	201 (7.7)

*Not mutually exclusive

In response to a question on influenza vaccination uptake among workforce (reported separately for staff, agency staff and volunteers) and care recipients in the past 12 months, most services reported low vaccination uptake for staff, agency staff and volunteers, with a high proportion not reporting any known rates among agency staff and volunteers (77.9% and 75%, respectively) (**Table 8 and Figure 1**). The proportion of RACS achieving different vaccination rates, after excluding those that responded 'unknown', is shown in **Table 9**. The proportions of RACS that reported $\geq 95\%$ vaccination rates among staff, agency staff, volunteers and care recipients were 3.5% (73/2089), 8.6% (50/577), 19% (124/652) and 35.9% (852/2372), respectively.

Table 8. Proportion of RACS reporting data on influenza vaccination coverage in workforce and care recipients in the past 12 months (n=2609)

Reported vaccination rate	0%	1–<25%	25–49%	50–74%	75–100%	Unknown
	n/N (%)	n/N (%)	n/N (%)	n/N (%)	n/N (%)*	n/N (%)
In the past 12 months, what percentage of the following staff had an influenza vaccination (number between 0 and 100 or unknown)						
Staff	8/2609 (0.3)	350/2609 (13.4)	786/2609 (30.1)	548/2609 (21)	397/2609 (15.2)	520/2609 (19.9)
Agency staff	498/2609 (19.1)	17/2609 (0.7)	–	4/2609 (0.2)	58/2609 (2.2)	2032/2609 (77.9)
Volunteer	255/2609 (9.8)	102/2609 (3.9)	44/2609 (1.6)	68/2609 (2.4)	183/2609 (6.8)	1957/2609 (75)
Care recipients	3/2609 (0.1)	33/2609 (1.3)	91/2609 (3.5)	323/2609 (12.4)	1922/2609 (73.7)	237/2609 (9.1)

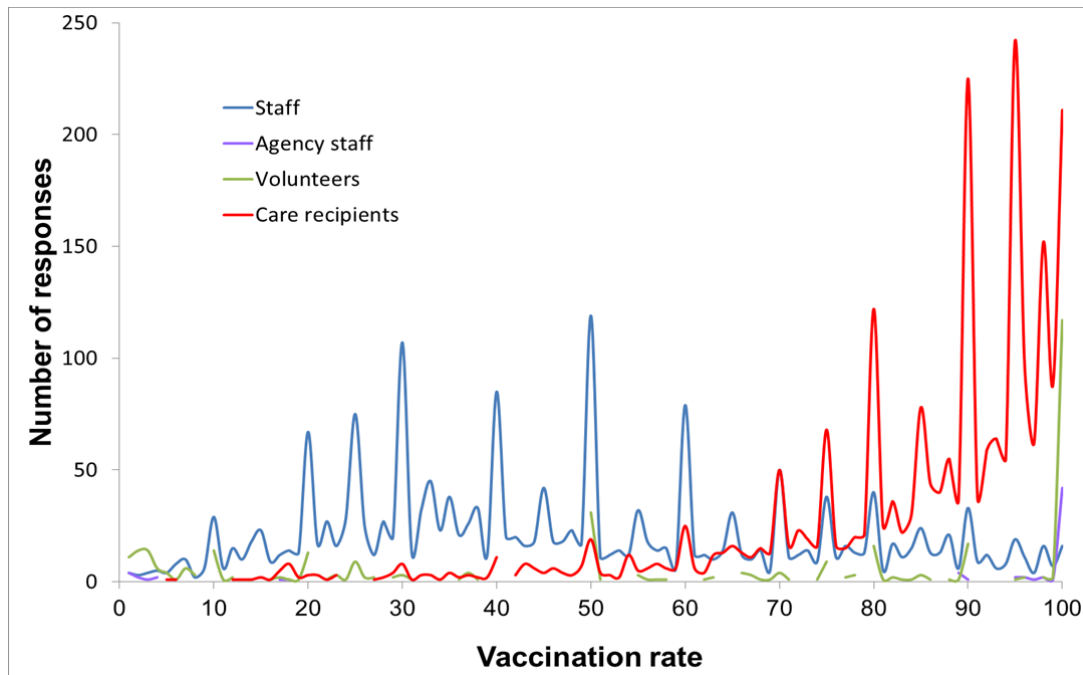
Table 9. Proportion of RACS with different vaccination coverage rates in workforce and care recipients in the past 12 months*

Reported vaccination rate	0%	1-<25%	25-49%	50-74%	75-100%**
	n/N (%)	n/N (%)	n/N (%)	n/N (%)	n/N (%)*
In the past 12 months, what percentage of the following staff had an influenza vaccination (number between 0 and 100 or unknown)					
Proportion RACS reporting specified staff vaccination rate (n=2089)	8/2089 (0.4)	350/2089 (16.8)	786/2089 (37.6)	548/2089 (26.2)	397/2089 (19.0)
Proportion of RACS reporting specified agency staff vaccination rate (n=577)	498/577 (86.3)	17/577 (2.9)	–	4/577 (0.7)	58/577 (10.1)
Proportion of RACS reporting specified volunteer vaccination rate (n=652)	255/652 (39.1)	102/652 (15.7)	44/652 (6.7)	68/652 (10.4)	183/652 (28.1)
Proportion of RACS reporting specified care recipient vaccination rate (n=2372)	3/2372 (0.1)	33/2372 (1.4)	91/2372 (3.8)	323/2372 (13.6)	1922/2372 (81.0)

*Note, all rates have been calculated by excluding services that did not report a vaccination rate, i.e. where data were 'unknown'.

**This also includes RACS that achieved a vaccination rate of ≥95% (see text for details).

Figure 1. Reported vaccination rates for staff, agency staff, volunteers and care recipients in the past 12 months for each RACS



A potential influenza outbreak was reported to have occurred by 44.7% services (**Table 10**). A potential influenza outbreak was defined in the survey as three or more cases of influenza-like illness in care recipients or staff of a service within 3 days, and concluding 8 days after last symptoms. Most of those outbreaks affected care recipients and staff; some also affected volunteers and agency staff. Most outbreaks affected fewer than 20 individuals; larger outbreaks were uncommon among the workforce, but sometimes occurred among care recipients (**Table 10**).

Table 10. Influenza outbreaks in the past 12 months in RACS (n=2609)

	Yes n (%)	No n (%)			
Has the service had a potential influenza outbreak in the past 12 months?	1167 (44.7)	1442 (55.3)			
During the outbreak, how many people were identified as having potential influenza*?	<10 people	10-19 people	≥20 people	none	NA
• Care recipients	534 (20.4)	403 (15.4)	215 (8.1)	99 (3.8)	1358 52.1)
• Staff	757 (29)	161 (6.2)	41 (1.4)	282 (10.8)	1368 (52.4)
• Agency staff	17 (0.7)	2 (0.08)	–	602 (23.1)	1987 (76.2)
• Volunteers	44 (1.7)	1 (0.04)	–	877 (33.6)	1687 (64.7)

*If the service had more than one outbreak in the past 12 months, they were asked to provide details of the outbreak that affected the most care recipients/workforce

NA = Not applicable

A gastroenteritis outbreak in the past 12 months was reported to have occurred in 30.5% of services and mostly affected care recipients and staff (**Table 11**). Most of the outbreaks affecting staff involved fewer than 20 individuals. Among care recipients, both smaller and larger outbreaks were reported (**Table 11**), with nine services reporting outbreaks that affected more than 50 people.

Table 11. Gastroenteritis outbreaks in the past 12 months in RACS (n=2609)

	Yes n (%)	No n (%)			
Has the service had a gastroenteritis outbreak in the past 12 months?	796 (30.5)	1813 (69.5)			
During the outbreak, how many people were identified as having gastroenteritis*?	<10 people	10-19 people	≥20 people	none	NA
• Care recipients	290 (11.1)	232 (8.9)	266 (10.2)	103 (3.9)	1718 (65.8)
• Staff	455 (17.4)	130 (5)	40 (1.4)	266 (10.4)	1718 (65.8)
• Agency staff	11 (0.44)	1 (0.04)	1 (0.04)	497 (19)	2099 (80.5)
• Volunteers	16 (0.64)	2 (0.08)	–	694 (26.6)	1897 (72.7)

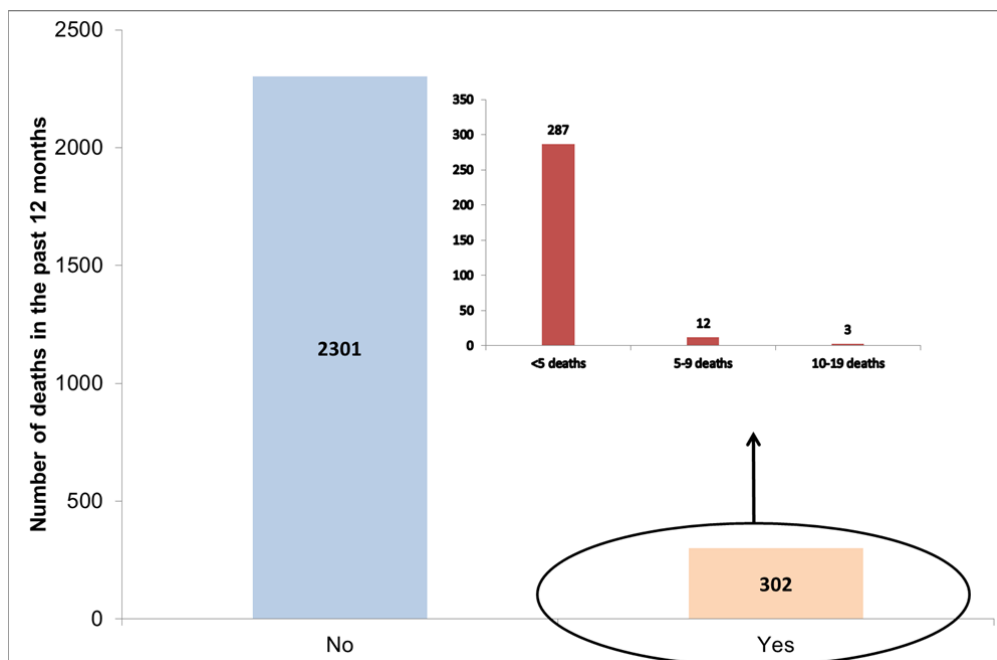
*If the service had more than one outbreak in the past 12 months, they were asked to provide details of the outbreak that affected the most care recipients/workforce.

NA = Not applicable

Influenza or gastroenteritis outbreaks reportedly resulted in the deaths of care recipients in 11.6% (n=302) of services. The number of fatalities ranged from 1 to 18. Of the RACS reporting fatalities, 287 reported fewer than 5 deaths, 12 reported 5–8 deaths and 3 reported between 10 and 20 deaths (12, 14 and 18 deaths, respectively) among care recipients (**Figure 2**). Any analysis of deaths from influenza and gastroenteritis outbreaks had significant limitations due to the survey design. (These limitations are discussed on page 37). The number of reported deaths has not been systematically verified and may be inaccurate.

It was not possible to differentiate between the number of deaths attributed to influenza and gastroenteritis. The question asked in the survey was, “Has any influenza or gastroenteritis outbreak in the past 12 months resulted in the death of one or more care recipients?” (see Appendix 1. RACS Survey).

Figure 2. RACS reporting that an influenza or gastroenteritis outbreak resulted in death in a care recipient/s in the past 12 months



Most services stated that they reported all outbreaks to their state/territory health department and maintained a register of the outbreaks. However, a small proportion (2.4%) did not report the outbreaks and 3.3% services did not maintain a register (**Table 12**).

Table 12. Reporting and registering all outbreaks in the past 12 months in RACS (n=2609)

	Yes n (%)	No n (%)	Not applicable n (%)
Has the service <u>reported all outbreaks</u> in the past 12 months to the state/territory Department of Health public health unit?	1598 (61.2)	62 (2.4)	949 (36.4)
Does the service maintain a <u>current register</u> of notifications of cases to the state/territory Department of Health public health unit?	2100 (80.5)	85 (3.3)	424 (16.3)

When asked if there has been any adverse finding about the service by another regulatory agency or oversight body in the past 12 months in relation to infection control and outbreak management, 27 (1%) reported adverse findings ranging in number from 1 to 8 (median 4, mean 4.3). These adverse findings were mainly reported by food safety authority (0.6%) or state/territory department of health (0.5%) and in a very small proportion by other agencies such as aged care complaints commissioner (0.08%) (Table 13).

Table 13. Adverse findings about the service in the past 12 months (n=2609)

	Yes n (%)	No n (%)
Has there been any adverse finding about the service by another regulatory agency or oversight body in the past 12 months in relation to infection control and outbreak management?	27 (1)	2582 (99)
If Yes, how many adverse findings have been made?*	Range 1-8 Median 4 Average 4.3	
If Yes, relevant agencies that made an adverse finding about the service:**		
• Healthcare Complaints Commission	–	
• Aged Care Complaints Commissioner	2 (0.08)	
• Coroner	–	
• Workers compensation authority	–	
• State/territory Department of Health public health unit	14 (0.5)	
• Food safety authority	16 (0.6)	
• Australian Council on Healthcare Standards	–	
• Other	3 (0.1)	
• Not applicable	–	

*These numbers when added exceed 27 (number of service providers answering 'yes' in the previous question on whether there has been any adverse finding about the service by another regulatory agency or oversight body in the past 12 months). Although 27 service providers said there were adverse findings, 33 actually reported one or more adverse findings.

** These numbers when added exceed 27 (number of service providers answering 'yes' in the previous question on whether there has been any adverse finding about the service by another regulatory agency or oversight body in the past 12 months). Although 27 service providers said there were adverse findings, 34 named relevant agencies that made an adverse finding about the service, reporting more than one agency (a food safety authority, a state/territory department of health public health unit and another agency not specified).

4. Infection control processes

The processes for responding to an outbreak are summarised in **Table 14**. In over 95% of services, various components of a response plan were in place. A lower proportion of services (89.1%) stated that they had a procedure to review care recipients' temperature monitoring charts (**Table 14**).

Table 14. Processes for responding to an outbreak in RACS (n=2609)

	Yes n (%)	No n (%)
Does the service have an <u>outbreak management plan</u> where an outbreak is suspected or identified?	2590 (99.3)	19 (0.7)
Does the service have an <u>identified central point of responsibility</u> for infection control?	2523 (96.7)	86 (3.3)
Does the service have <u>standard communication & risk alert material</u> to notify workforce, care recipients and their representatives about outbreaks?	2589 (99.2)	20 (0.8)
Does the service have <u>procedure for notifying</u> the relevant state/territory Department of Health PHU or any relevant authority?	2588 (99.2)	21 (0.8)
Does the service have processes, facilities and compliance checks for hand hygiene practices?	2566 (98.4)	43 (1.6)
Does the service have strategy to increase hygiene measures where an outbreak is suspected or identified?	2573 (98.6)	36 (1.4)
Does the service have review of compliance with food safety standards?	2555 (97.9)	54 (2.1)
Does the service have standard practices for maintaining a clean hygienic environment?	2601 (99.7)	8 (0.3)
Does the service have procedure to access expert advice on infection control?	2489 (95.4)	120 (4.6)
Does the service have outbreak kits containing protective clothing?	2579 (98.9)	30 (1.1)
Does the service have procedure for documenting onset of gastro or influenza symptoms including number of care	2573 (98.6)	36 (1.4)

recipients/staff affected, symptoms and other persons at risk?		
Does the service have instructions on implementing containment actions?	2550 (97.7)	59 (2.3)
Does the service have isolation procedure for affected care recipients?	2569 (98.5)	40 (1.5)
Does the service have strategy for excluding infected staff from work?	2590 (99.3)	19 (0.7)
Does the service have restricted contact procedures?	2574 (98.7)	35 (1.3)
Does the service have procedure for collecting, managing and storing specimens for pathology assessment?	2536 (97.2)	73 (2.8)
Does the service have risk alert information placed on public display in areas of reception and waiting areas?	2575 (98.7)	34 (1.3)
Does the service have procedure to review care recipients' temperature monitoring charts?	2324 (89.1)	285 (10.9)
Does the service have outbreak timeline records?	2486 (95.3)	123 (4.7)
Does the service have suitable container/s for safe disposal of tissues, gloves, masks etc.?	2571 (98.5)	38 (1.5)

5. Training

In the past 12 months, 96.4% (n=2516) of services provided staff training on the use of infection control guidelines. However, only 81.9% and 81.4% of services provided specific training on the use of outbreak kits for influenza and gastroenteritis, respectively (**Table 15**).

Table 15. Staff training provided in the past 12 months in RACS (n=2609)

	Yes n (%)
In the past 12 months, has the service provided staff training on the use of <i>Outbreak kit for influenza</i> ?	2136 (81.9)
In the past 12 months, has the service provided staff training on the use of <i>Outbreak kit for gastroenteritis</i> ?	2125 (81.4)
In the past 12 months, has the service provided staff training on the use of <i>Infection control guidelines</i> ?	2516 (96.4)

6. Continuous improvement

When asked if the effectiveness of their infection control system is regularly reviewed, 98.5% of RACS answered affirmatively; 97.5% reported that it was reviewed following an infectious outbreak and 94.8% reported that the service has a continuous improvement plan (**Table 16**).

Table 16. Continuous improvement of infection control in RACS (n=2609)

	Yes n (%)
Is the effectiveness of the infection control system regularly reviewed?	2569 (98.5)
Is the infection control system reviewed following an infectious outbreak?	2544 (97.5)
Does the service have a continuous improvement plan which shows implementation, regular review, revision and evaluation of outcomes?	2473 (94.8)

When asked how they rated their infection control management, 52.4% of RACS considered that they followed best practice, 45% rated themselves as satisfactory and only 2.6% thought they needed improvement (**Table 17**).

Table 17. Self-rating of service's infection control management (n=2609)

	In need of improvement n (%)	Satisfactory n (%)	Best practice n (%)
How would you rate your Service's infection control management?	68 (2.6)	1174 (45)	1367 (52.4)

7. Association between infection control plans and outbreaks

There was no significant difference between the proportion of influenza and gastroenteritis outbreaks in the RACS that had corresponding infection control plans in place compared with those with no infection control plan (**Table 18**), noting that most services reported having plans.

8. Association between infection control plans and staff influenza vaccination

Having an infection control plan for influenza and other respiratory viruses was associated with improved influenza vaccination rates among staff (**Table 18**).

Table 18. Association between infection control plan and outbreaks and vaccination in RACS

	Infection Control Plan*		Total n	χ^2 p value
	Yes n	No n		
RACS with influenza outbreaks in care recipients				
Yes	1145	1408	2553	$\chi^2=0.67$ p=0.49
No	22	34	56	
Total	1167	1442	2609	
RACS with gastroenteritis outbreaks in care recipients				
Yes	795	1805	2600	$\chi^2=1.6$ p=0.37
No	1	8	9	
Total	796	1813	2609	
Staff influenza vaccination rates (range)*				
1–24%	346	4	350	$\chi^2=15.4$ p<0.01
25–49%	760	26	786	
50–74%	540	8	548	
≥75%	395	2	397	
Unknown	504	16	520	
0%	8	0	8	
Total	2553	56	2609	

* The association between staff influenza vaccination rates (not including agency staff and volunteers) and infection control plan was compared for RACS with and without an infection control plan for influenza and other respiratory viruses.

9. Association between staff vaccination and outbreaks

The association between staff vaccination and outbreaks was examined using reported vaccination rates for staff, not including vaccination rates for agency staff and volunteers. The higher the staff vaccination rate, the lower the proportion of RACS reporting influenza outbreaks (**Table 19**). For instance, 48.6% of RACS that reported staff influenza vaccination coverage of <25% reported potential influenza outbreaks compared with 39.3% of RACS reporting staff coverage of ≥75% (**Table 19**).

Similarly, the higher the reported staff influenza vaccination rate, the lower the proportion of RACS reporting gastrointestinal outbreaks (**Table 19**). For instance, 35.4% (124/350) of the RACS reporting staff influenza vaccination coverage of <25% reported gastrointestinal outbreaks while only 20.7% (82/397) of RACS reporting vaccination coverage of ≥75% reported gastrointestinal outbreaks (**Table 19**).

10. Association between care recipient vaccination and outbreaks

Influenza and gastroenteritis outbreaks in RACS occurred despite a high uptake of influenza vaccine among care recipients in some services (**Table 20**). For example, up to 47.5% (913/1922) of RACS achieving influenza vaccine coverage of ≥75% among care recipients reported influenza outbreaks (**Table 20**).

Table 19. Association between staff influenza vaccination rates and outbreaks in care recipients in RACS (n=2609)

Staff influenza vaccination (% range)	Yes	No	Total	χ^2
RACS with influenza outbreaks in care recipients				
	n	n	n	p value
1–24%	170	180	350	$\chi^2=27.2$
25–49%	386	400	786	
50–74%	259	289	548	
≥75%	156	241	397	
Unknown	194	326	520	p<0.01
0%	2	6	8	
Total	1167	1442	2609	
RACS with gastroenteritis outbreaks in care recipients				
1–24%	124	226	350	$\chi^2=33.2$
25–49%	277	509	786	
50–74%	150	398	548	
≥75%	82	315	397	
Unknown	161	359	520	p<0.01
0%	2	6	8	
Total	796	1813	2609	

Table 20. Association between care recipient influenza vaccination rate and outbreaks among care recipients in RACS (n=2609)

Care recipient influenza vaccination (% range)	Yes	No	Total	χ^2
	n	n	n	p value
RACS with influenza outbreaks in care recipients				
1–24%	14	19	33	$\chi^2=37.3$ p<0.01
25–49%	33	58	91	
50–74%	140	183	323	
≥75%	913	1009	1922	
Unknown	67	170	237	
0%	0	3	3	
Total	1167	1442	2609	
RACS with gastroenteritis outbreaks in care recipients				
1–24%	3	30	33	$\chi^2=8.9$ p<0.11
25–49%	30	61	91	
50–74%	101	222	323	
≥75%	587	1335	1922	
Unknown	75	162	237	
0%	0	3	3	
Total	796	1813	2609	

11. Association between remoteness and outbreaks of influenza and gastroenteritis

Remoteness appeared inversely related to gastrointestinal outbreaks, but this may not be a reliable finding as the number of remote/very remote RACS is small. There was no significant association between remoteness and influenza outbreaks (**Table 21**).

Table 21. Association between remoteness and outbreaks of influenza and gastrointestinal among care recipients

Remoteness	Outbreaks		Total n	χ^2 p value
	Yes n	No n		
Influenza outbreaks				
Major cities	738	878	1616	$\chi^2=8.5$ $p=0.07$
Inner region	281	343	624	
Outer region	136	189	325	
Remote	10	20	30	
Very remote	2	12	14	
Total	1167	1442	2609	
Gastroenteritis outbreaks				
Major cities	529	1087	1616	$\chi^2=17.7$ $p<0.01$
Inner region	184	440	624	
Outer region	77	248	325	
Remote	3	27	30	
Very remote	3	11	14	
Total	796	1813	2609	

12. Association between documentation of vaccination and vaccination rate

Documentation of influenza vaccine receipt was associated with improved vaccination rate among staff, agency staff, volunteers and care recipients (**Table 22**).

Table 22. Association between documentation of receipt of vaccination and vaccination coverage among staff, agency staff, volunteers and care recipients

Influenza vaccination (% range)	Documentation of vaccination			χ^2 p value
	Yes n	No n	Total n	
Staff vaccination				
1–24%	240	110	350	$\chi^2=48.4$ p<0.01
25–49%	620	166	786	
50–74%	463	85	548	
≥75%	360	37	397	
Unknown	125	395	520	
0%	2	6	8	
Total	1810	799	2609	
Agency staff vaccination				
1–24%	6	11	17	$\chi^2=308.9$ p<0.01
25–49%	--	--	--	
50–74%	1	3	4	
≥75%	22	36	58	
Unknown	45	1987	2032	
0%	7	491	498	
	81	2528	2609	
Volunteer vaccination				
1–24%	59	43	102	$\chi^2=567.1$ p<0.01
25–49%	26	18	44	
50–74%	42	26	68	
≥75%	96	87	183	
Unknown	171	1786	1957	
0%	23	232	255	
Total	417	2192	2609	
Aged care recipient vaccination				
1–24%	22	11	33	$\chi^2=203.2$ p<0.01
25–49%	72	19	91	
50–74%	261	62	323	
≥75%	1531	391	1922	
Unknown	91	146	237	
0%	2	1	3	
Total	1979	630	2609	

Documentation of staff vaccination was more common in RACS that reported influenza outbreaks (**Table 23**). Services that provided staff training on the use of the outbreak kit for influenza were more likely to report outbreaks to the state health departments (**Table 24**).

Table 23: Documentation of staff influenza vaccination and influenza outbreak

Staff vaccination documented	Potential influenza outbreak		% RACS having influenza outbreaks	X ² and p values
	No	Yes		
Yes	973	837	46.2	X ² =5.5 p=0.02
No	469	330	41.3	

Table 24. Association between staff training and reporting outbreaks to the state/territory health departments

Services provided staff training on flu outbreak	Reported outbreaks to the state/territory health departments			% RACS reporting outbreaks to the state/territory health departments	X ² and P values
	No	Yes	NA		
Yes	46	1373	717	64.3	X ² = 45.6 <0.01
No	16	225	232	47.6	

13. Association between training & education and influenza outbreaks

RACS that provided staff training on the use of the outbreak kit for influenza had a significantly higher proportion of influenza outbreaks (48.6% versus 27.3%; p<0.01) (Table 25).

Table 25. Association between staff training and influenza outbreaks in RACS

	Influenza outbreak		Total	RACS with outbreak (%)	
	No	Yes			
In the past 12 months has the Service provided staff training on the use of the outbreak kit for influenza?	Yes	1098	1038	2136	48.6
	No	344	129	473	27.3

14. Association between training & education and gastrointestinal outbreaks

RACS that provided staff training on the use of the outbreak kit for gastroenteritis had a significantly higher percentage of gastrointestinal outbreaks (33.7% versus 16.5%; p<0.01) (Table 26).

Table 26. Association between staff training and gastroenteritis outbreaks

		Gastroenteritis outbreak			RACS with outbreak	
		No	Yes	Total	%	
In the past 12 months has the Service provided staff training on the use of the outbreak kit for gastroenteritis?	Yes	1409	716	2125	33.7	
	No	404	80	484	16.5	

15. Association between providing access to influenza vaccine at the RACS and vaccine uptake

While exploring association between providing staff and care recipients access to influenza vaccine at the RACS or encouraging them to get the vaccine from an external provider (e.g. GP) and vaccine uptake, it was found that RACS that provided vaccines achieved higher vaccination rates compared with RACS that encouraged staff and care recipients to go to an external provider for influenza vaccination. The association was statistically significant for staff, volunteers and care recipients but not for agency staff (Table 27).

Table 27. Providing access to influenza vaccines at RACS and vaccination rate

Vaccination rate (% range)	Influenza vaccination		Total	χ^2
	Providing access to influenza vaccination n	Did not report providing access to the vaccine but encouraged person to go to other provider (e.g.GP) n	n	p value
Staff				
1–24%	299	36	335	$\chi^2=294.8$ p<0.01
25–49%	723	34	757	
50–74%	514	14	528	
≥75%	372	19	391	
Unknown	342	142	484	
0%	3	5	8	
Total	2253	250	2503	
Agency staff				
1–24%	15	2	17	$\chi^2=8$ p=0.09
25–49%	--	--	0	
50–74%	3	1	4	
≥75%	56	0	56	
Unknown	1746	203	1949	
0%	433	44	477	
Total	2253	250	2503	
Volunteers				
1–24	93	6	99	$\chi^2=16.2$ p<0.01
25–49	42	1	43	
50–74	62	3	65	
≥75	170	7	177	
Unknown	1668	205	1873	
0%	218	28	246	
Total	2253	250	2503	
Care recipients				
1–24%	24	7	31	$\chi^2=36.8$ p<0.01
25–49%	57	27	84	
50–74%	213	77	290	
≥75%	1460	307	1767	
Unknown	150	60	210	
0%	1	2	3	
Total	1905	480	2385	

16. Association between providing influenza vaccine at the RACS and influenza outbreaks

Providing care recipients access to influenza vaccine at the RACS was associated with fewer influenza outbreaks compared to limiting provision to encouraging care recipients to receive the vaccine from an external provider such as GPs (45.5% [867/1905] versus 40.2% [193/480]; $p=0.04$). This association was not statistically significant for different means of vaccine delivery for staff (**Table 28**).

Table 28. Association between providing influenza vaccine at the RACS and influenza outbreaks

Influenza vaccination program	Outbreak		Total n	χ^2 p value
	Yes	No		
Staff				
Providing access to vaccination	123	0	1023	$X^2=3.1$ $p=0.08$
Encouraged to go to other provider (e.g.GP)	151	99	250	
Total	138	1122	2503	
Care recipients				
Providing access to vaccination	867	1038	1905	$X^2=4.4$ $p=0.04$
Encouraged to go to other provider (e.g.GP)	193	287	480	
Total	106	1325	2385	

Survey design and analysis limitations

Although this was a large survey conducted within a short time-frame with a large sample size and high response rate (2609/2704 RACS; response rate 96.5%), there were some limitations of the study design and analysis. Most the questions were closed-ended.

However, the design of the survey allowed participants to answer any sub-question, even if they answered 'no' to the initial related question. This affected total response numbers in some cases and may have thus affected proportions reported for some survey questions.

The analysis of deaths from influenza and gastroenteritis outbreaks had significant limitations. First, it did not allow differentiation between influenza-like illness and gastroenteritis-related fatalities. Second, there was no clarification sought from respondents about whether reported deaths were confirmed as influenza-related deaths through laboratory testing or were due to 'influenza-like illnesses' (which does not require laboratory confirmation of the virus). Thus, the number of reported deaths has not been systematically verified and may be inaccurate. Each state and territory department of health captures data on deaths from influenza and potentially on deaths in RACS using different methods; there is no one surveillance system that accurately captures all deaths that may be attributable to influenza in RACS nationally.¹ An alternative source of information regarding overall causes of death in aged care is the Australian Institute of Health and Welfare's 'Cause of death pattern and people use of age care'.¹¹

In addition, the total number of outbreaks in the past 12 months reported by each RACS was not recorded: information on the number of staff and/or care recipients was provided in relation to the largest outbreak experienced.^{1, 11} Outbreaks have generally been referred to as being from influenza; however, detail was not requested regarding whether outbreaks were confirmed as being from influenza on the basis of laboratory testing or outbreaks were due to influenza-like illness.

As with any survey, recall bias may have affected responses. However, services were asked for information from the past 12 months that should have been available from their records.

Finally, this survey relied on reporting by a member of each RACS. No additional measures were taken to confirm or validate data provided in this survey from each RACS. The findings from this report will provide for opportunities to further validate these data and to undertake additional activities related to infection prevention and control in the future.

Conclusion

This nationwide survey provides a baseline picture of infection prevention and control practices in RACS using data self-reported by each service. Overall, information in the survey, such as vaccination rates of both workforce and care recipients, provides insights into current practice and potential ways to improve the prevention and management of influenza and gastrointestinal diseases in these services. These self-reported practices and associations should, however, only be used as a starting point for further

investigation, not as definitive proof of association between practices and outcomes reported by the services.

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Appendix 1. RACS survey

RACS Id

Service Name

Provide the RACS Id for the Service.

Approved Provider

Provide the Name of the Approved Provider for the Service

No. of Allocated Places

Provide the number of Approved Allocated Places for the Service

No. of Staff

This is the number of staff who work at the Service. This includes any casual or part-time staff at the Service.

No. of Volunteers

This is the number of people who regularly volunteer at the Service

Postcode

Provide the postcode associated with the location of the Service.

Authority full name

Position at Service

The position that is held at the Service

Approve Submission

By ticking this box I am declaring that I am authorised to provide the information in this form as a delegate of the above Approved Provider for the Service named. I also declare that the information is correct at the date of submission.

Please note this form requires an answer to every question.

Governance

Question 1

Does the Service have an infection control plan to prevent, identify and contain influenza and other respiratory viruses?

Yes

No

Question 1a

If yes, was it reviewed in the last 12 months?

Yes

No

Not applicable

Question 2

Does the Service have an infection control plan to prevent, identify and contain gastroenteritis?

Yes

No

Question 2a

If yes, was it reviewed in the last 12 months?

Yes

No

Not applicable

Immunisation

Question 3

Does the Service have an annual influenza vaccination program for the workforce?

Yes

No

Question 3a

If yes in Question 3, is participation in the program mandatory?

Yes

No

Not applicable

Question 3b

If yes in Question 3, does the Service:

- Provide access to influenza vaccination for staff
- Encourage staff to go to an external provider (e.g. GP)
- None of the above

Question 4

Does the Service have a policy about vaccination for staff in the following categories?

(check all boxes that apply)

- All Staff
- Nurse practitioners
- Registered nurses
- Enrolled nurses
- Personal care attendants
- Allied health professionals
- Allied health assistants
- Management
- Administration
- Spiritual/pastoral care
- Ancillary care
- Maintenance and cleaning
- Catering and food preparation
- Volunteers
- None of the above

Question 5

Does the Service have an annual influenza vaccination program for the care recipients?

Yes

No

Question 5a

If yes in Question 5, is participation in the program mandatory?

Yes

No

Not applicable

Question 5b

If yes in Question 5, does the Service:

- Provide access to influenza vaccination for care recipients
- Encourage care recipients to go to an external provider (e.g. GP)
- None of the above
- Not applicable

Question 6

Does the Service maintain a current register of influenza vaccination records for the following? (check all boxes that apply)

Staff Agency staff

Volunteers

Care recipients

No register is kept

Question 6a

If yes, do the following provide evidence of their vaccination e.g. documentation or receipt? (check all boxes that apply)

Staff

Agency staff

Volunteers

Care recipients

No evidence required

No register is kept

Question 7a

In the past 12 months what percentage of Staff had an influenza vaccination? (enter a number between 0-100 or unknown if the percentage is not known)

Question 7b

In the past 12 months what percentage of Agency Staff had an influenza vaccination?
(enter a number between 0-100 or unknown if the percentage is not known)

Question 7c

In the past 12 months what percentage of Volunteers had an influenza vaccination? (enter a number between 0-100 or unknown if the percentage is not known)

Question 7d

In the past 12 months what percentage of Care Recipients had an influenza vaccination?
(enter a number between 0-100 or unknown if the percentage is not known)

Monitoring and Reporting

Question 8

Has the service had a potential influenza outbreak in the past 12 months? (A potential influenza outbreak is 3 or more cases of influenza-like illness in care recipients or staff of a service within 3 days concluding 8 days after last symptoms)

Yes

No

Question 8a

If yes, during the outbreak how many Care Recipients were identified as having potential influenza? (If the service has had more than one influenza outbreak please provide details of the outbreak that affected the most care recipients)

Question 8b

If yes, during the outbreak how many Staff were identified as having potential influenza? (If the service has had more than one influenza outbreak please provide details of the outbreak that affected the most care recipients)

Question 8c

If yes, during the outbreak how many Agency Staff were identified as having potential influenza? (If the service has had more than one influenza outbreak please provide details of the outbreak that affected the most care recipients)

Question 8d

If yes, during the outbreak how many Volunteers were identified as having potential influenza? (If the service has had more than one influenza outbreak please provide details of the outbreak that affected the most care recipients)

Question 9

Has the Service had a gastroenteritis outbreak in the past 12 months? (A gastroenteritis outbreak is 2 or more people ill with vomiting or diarrhoea within 24 hours of each other concluding 4 days after last symptoms)

Yes

No

Question 9a

If yes, during the outbreak how many Care Recipients were identified as having gastroenteritis? (If the service has had more than one gastroenteritis outbreak please provide details of the outbreak that affected the most care recipients)

Question 9b

If yes, during the outbreak how many Staff were identified as having gastroenteritis? (If the service has had more than one gastroenteritis outbreak please provide details of the outbreak that affected the most care recipients)

Question 9c

If yes, during the outbreak how many Agency Staff were identified as having gastroenteritis? (If the service has had more than one gastroenteritis outbreak please provide details of the outbreak that affected the most care recipients)

Question 9d

If yes, during the outbreak how many Volunteers were identified as having gastroenteritis? (If the service has had more than one gastroenteritis outbreak please provide details of the outbreak that affected the most care recipients)

Question 10

Has any influenza or gastroenteritis outbreak in the past 12 months resulted in the death of one or more care recipients?

Yes

No

Question 10a

If yes, please provide the number of care recipients. (Enter NA if not applicable).

Question 11

Has the Service reported all outbreaks in the past 12 months to the state/territory Department of Health public health unit?

Yes

No

Not applicable

Question 12

Does the Service maintain a current register of notifications of cases to the state/territory Department of Health public health unit?

Yes

No

Not applicable

Question 13

Have there been any adverse findings about the Service by another regulatory agency or oversight body in the last 12 months in relation to infection control and outbreak management?

Yes

No

Question 13a

If yes, how many adverse findings have been made?

Question 13b

If yes, tick the relevant agency/ies which made an adverse finding about the Service:
Healthcare Complaints Commission

Aged Care Complaints Commissioner
The coroner
Workers compensation authority
A state/territory Department of Health public health unit
A food safety authority
Australian Council on Healthcare Standards
Other
Not applicable

Infection Control Processes

Question 14

Does the Service have the following in place to respond to an infection outbreak: (check all boxes that apply)

- An outbreak management plan where an outbreak is suspected or identified
- An identified central point of responsibility for infection control
- Standard communication and risk alert material to notify the workforce, care recipients and their representatives about infectious outbreaks
- Procedure for notifying the relevant state/territory Department of Health public health unit and/or any other relevant authority
- Processes, services and compliance checks for hand hygiene practices
- Strategy to increase hygiene measures where an outbreak is suspected or identified
- Review of compliance with food safety standards
- Standard practices for maintaining a clean and hygienic environment
- Procedure to access expert advice on infection control
- Outbreak kits containing personal protective clothing
- Procedure for documenting the onset of gastro or influenza symptoms; including number of care recipients/staff affected, symptoms and other persons at risk
- Instructions on implementing containment actions (restricting access, segregations, additional staff, cleaning, appropriate disposal units, use of meal trays)
- Isolation procedure for affected care recipients
- Strategy for excluding infected staff from work
- Restricted contact procedures (staff movement restricted, visitors kept to minimum/short duration) Procedure for collecting, managing and storing

- specimens for pathology assessment
- Risk alert information placed on public display in areas such as reception and waiting areas
 - Procedure to review care recipients' temperature monitoring charts
 - Outbreak timeline records
 - Suitable container/s for safe disposal of tissues, gloves, masks, single-use towelling etc.
 - None of the above

Training

Question 15a

In the past 12 months has the Service provided staff training on the use of the Outbreak kit for influenza?

Yes

No

Question 15b

In the past 12 months has the Service provided staff training on use of the Outbreak kit for gastroenteritis?

Yes

No

Question 15c

In the past 12 months has the Service provided staff training on use of the Infection control guidelines?

Yes

No

Continuous Improvement

Question 16

Is the effectiveness of the infection control system regularly reviewed?

Question 17

Yes

No

Is the infection control system reviewed following an infectious outbreak?

Yes

No

Question 18

Does the Service have a continuous improvement plan which shows implementation, regular review, revision and evaluation of outcomes?

Yes

No

Question 19

Overall, how would you rate your Service's infection control management?

- In need of improvement
- Satisfactory
- Best practice