



Healthcare
Management
Advisors

AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND
AGED CARE

**Evaluation of the Infection Prevention
and Control Nurse Lead role in
Residential Aged Care Homes**

FINAL REPORT

21 DECEMBER 2023



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TABLE OF CONTENTS

ABBREVIATIONS	I	3.2.1 Supporting documentation	14
EXECUTIVE SUMMARY	III	3.3 PROGRAM LOGIC	15
1 INTRODUCTION	1	Part B Evaluation findings	17
1.1 BACKGROUND	1	4 KEA 1: IMPLEMENTATION	18
1.2 PURPOSE AND STRUCTURE OF THIS DOCUMENT	1	KEY INSIGHTS 18	
Part A Context and evaluation approach	3	KEA 1 QUESTIONS	19
2 CONTEXT	4	ANALYSIS AND FINDINGS	19
2.1 POLICY AND ENVIRONMENTAL CONTEXT	4	4.1 ALIGNMENT OF THE IPC LEAD ROLE WITH AGED CARE QUALITY STANDARDS	19
2.2 IPC LEAD ROLE TRAINING AND SUPPORTS	7	4.2 IPC LEAD UPTAKE AND IMPLEMENTATION	20
2.3 REGULATORY CONTEXT	7	4.2.1 Variation in implementation of the IPC Lead role	21
2.3.1 Aged care home consumer reporting requirements	8	4.2.2 Impacts from the implementation of different numbers of IPC Leads	22
2.4 CURRENT IPC LEAD ROLE ARRANGEMENTS	8	4.3 OUTBREAK MANAGEMENT	23
2.4.1 IPC Lead training requirements and funding support	9	4.4 OPPORTUNITIES TO ADAPT	24
2.4.2 IPC Lead program reporting requirements	9	4.4.1 Modification of the IPC Lead role in aged care homes	24
2.5 NURSING WORKFORCE CONSIDERATIONS	10	4.4.2 Modification of the IPC Lead role in other aged care settings	24
2.6 RECENT EVIDENCE ON BEST PRACTICE APPROACHES TO IPC IN AGED CARE HOMES	11	4.4.3 Lessons learnt from the implementation of the IPC Lead	25
3 EVALUATION APPROACH	13	5 KEA 2: APPROPRIATENESS	27
3.1 OVERVIEW	13	KEY INSIGHTS 27	
3.2 METHOD	13	KEA 2 QUESTIONS	27

TABLE OF CONTENTS

ANALYSIS AND FINDINGS	27	7.4 APPROPRIATENESS OF IPC TRAINING	38
5.1 SATISFACTION WITH THE IPC LEAD ROLE	27	7.5 IMPACT OF STAFF TURNOVER	38
5.2 CONSUMER PERCEPTION OF THE IPC LEAD ROLE	28	8 SWOT ANALYSIS	40
5.2.1 Consumer Experience and Quality of Life indicators	28	9 KEY FINDINGS AND RECOMMENDATIONS	43
5.2.2 Consumer awareness	29	9.1 KEY FINDINGS, OPPORTUNITIES AND RECOMMENDATIONS	43
5.3 FELT SUPPORT FOR IPC LEADS	30	9.2 PRIORITISATION OF RECOMMENDATIONS	48
5.4 IMPROVEMENT IN DELIVERY OF SAFE CARE	30	10 APPENDICES	49
6 KEA 3: SUPPORT	32	APPENDIX A AGED CARE HOME IPC POLICIES AND PRACTICES IN OTHER OECD COUNTRIES	49
KEY INSIGHTS 32		APPENDIX B ACQSC DATA	52
KEA 3 QUESTIONS	32	APPENDIX C AGED CARE SECTOR GROUPS INVITED FOR CONSULTATION	55
ANALYSIS AND FINDINGS	32	APPENDIX D CASE STUDY SITE SELECTION CRITERIA AND SAMPLE FRAME	56
6.1 INVESTMENT IN THE IPC LEAD ROLE	32	APPENDIX E IPC LEAD FRAMEWORK	63
6.2 ACCESSIBLE IPC TRAINING	33	APPENDIX F REFERENCES	67
6.3 OPPORTUNITIES TO IMPROVE SUPPORT	33		
6.3.1 Access to IPC expertise and peer support	33		
6.3.2 Training	34		
6.4 IMPACT OF REMOTENESS CLASSIFICATION ON IMPLEMENTATION	34		
7 KEA 4: IMPACT	36		
KEY INSIGHTS 36			
KEA 4 QUESTIONS	36		
ANALYSIS AND FINDINGS	36		
7.1 IMPACT ON NURSING SECTOR	36		
7.2 IMPACT ON NURSING ROLE	37		
7.3 BARRIERS AND CHALLENGES TO MEET IPC LEAD REQUIREMENTS	37		

ABBREVIATIONS

ABBREVIATION	DEFINITION
ACFR	Aged Care Financial Report
ACIPC	Australasian College for Infection Prevention and Control
ACQSC	Aged Care Quality and Safety Commission
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHPPC	Australian Health Protection Principal Committee
AHPRA	Australian Health Practitioner Regulatory Authority
COTA	Council on the Ageing
CPD	Continuing professional development
EN	Enrolled nurse
FTE	Full time employed
HAI	Hospital acquired infections
HMA	Healthcare Management Advisors

ABBREVIATION	DEFINITION
HREC	Human research ethics committee
IPC	Infection, prevention and control
KEA	Key evaluation area
MPS	Multi-purpose service
NATSIFAC	National Aboriginal and Torres Strait Islander Flexible Aged Care
PHN	Primary Health Networks
PHU	Public Health Unit
PPE	Personal protection equipment
QI	Quality Indicators
RAT	Rapid antigen test
RES	Residential Experience Survey

ABBREVIATIONS

ABBREVIATION	DEFINITION
RN	Registered nurse
SWOT	Strengths, weaknesses, opportunities, and threat
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

The Department of Health and Aged Care (the Department) engaged Healthcare Management Advisors (HMA) to evaluate the effectiveness of the Infection Prevention and Control Lead Nurse (IPC Lead) role program.

The IPC Lead role is a key component of reform efforts led by the Australian Government following a special report on COVID-19 and aged care that was produced by the Royal Commission into Aged Care Quality and Safety in 2020. All residential aged care homes were required to appoint an IPC Lead by 1 December 2020. This requirement is ongoing.

The IPC Lead role aims to increase IPC expertise across the aged care sector and offers a focal point for the Aged Care Quality and Safety Commission (ACQSC) to audit aged care homes regarding IPC capability.

EVALUATION FOCUS AND APPROACH

The evaluation assessed the introduction of the IPC Lead role on IPC capability in residential aged care homes with a focus on:

- implementation
- perceived benefits and experiences of the aged care sector and service users
- drivers and support for the IPC Lead to undertake their role
- integration and alignment with the Australian Aged Care Quality Standards and other relevant guidelines
- awareness, knowledge, and adoption of IPC practices in aged care homes.

A mixed methods approach was undertaken using both quantitative and qualitative information to inform the analysis and responses to the evaluation questions. The evaluation was undertaken in stages as follows:

- Stage 1: Project initiation and planning.
- Stage 2: Situation analysis. A review of the IPC Lead role program documentation, policy environment, and benchmarking of other similar programs.
- Stage 3: Data infrastructure development and ethics. This project received ethics approval from Bellberry HREC and WA Country Health Service ethics (specific to WA MPS sites only).
- Stage 4: Data collection (stakeholder consultation). Consultation with the sector, aged care homes, and IPC Leads. This included a survey of current and former IPC Leads to ascertain reasons for leaving the role and drivers to undertake the IPC training and role along with their experiences.
- Stage 5: Case studies were undertaken with 18 aged care homes across Australia.
- Stages 6 and 7: Draft and finalisation of the evaluation report. Data from previous stages was reviewed and analysed to understand potential insights to the impact of the IPC Lead.

KEY FINDINGS

The evaluation focused on four key evaluation areas (KEA) as discussed below.

EXECUTIVE SUMMARY

KEA 1: Implementation

How well has the IPC Lead role been implemented by residential aged care services and what are the recommendations to improve it?

Overall, there was consensus that the IPC Lead role aligns with and contributes to meeting the Aged Care Quality Standards. The IPC Lead role provides a point of contact for ACQSC audits and Infection Control Management spot checks. However, providers use a range of approaches to work towards compliance with the Aged Care Quality Standards, including the use of external IPC consultants. To maximise results, a whole of organisation approach to IPC is required, including stronger engagement with residents' families, carers and friends.

The evaluation found that with no overarching guidance, working arrangements for IPC Leads varied widely between facilities due to variations in aged care home size, location, resident profile, and allocated responsibilities to the IPC Lead role. Complementary factors, such as vaccination (influenza, COVID-19), good clinical governance and overall workforce IPC capability also contributed to effective IPC in aged care facilities.

Staff turnover results in continued transition in IPC Leads, mitigated by the implementation of additional IPC Leads where possible. Ongoing funding for IPC training would reduce costs incurred to aged care homes.

Consolidated information, resources, and access to expertise (including peer support) were suggested improvements along with recognition of the role (remuneration, dedicated time).

KEA 2: Appropriateness

What is the perception and experience of the IPC Lead role by the aged care sector and other appropriate stakeholders?

There was a reported uplift in IPC capability across all aged care home staff, including improved IPC governance and education/training. However, variation in the level of support by aged care providers and lack of peer or expert support impacts the ability of the IPC Lead to undertake the role effectively.

There was an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends. However there are still pockets of resistance to acknowledging required IPC practices.

Stakeholders reported that the downstream effects of IPC practices largely impacted residents with dementia or other cognitive impairment issues, and those at the end of life. Reduced access to social supports and connections for these residents was perceived to be potentially detrimental. There was a felt need to further understand these impacts.

KEA 3: Support

How well has the IPC Lead role been supported?

Support for the IPC Lead role was evidenced by approximately 40% of aged care homes submitting applications for the IPC Training Grant in 2023, and 1,488 individual grant applications for course fees, study leave, and backfill costs.

However, areas for improvement were noted and stakeholders highlighted the need for:

- organisational leadership and management to support and drive ongoing improvement in IPC practices, and lead the management of outbreaks
- targeted training to supplement the core IPC training with a focus on aged care resident cohorts (e.g. dementia, palliative care) and a practical application to the aged care setting
- a community of practice for IPC Leads to access and participate in, with IPC expertise to provide guidance and support to aged care homes
- ongoing funding for professional development in IPC.

EXECUTIVE SUMMARY

KEA 4: Impact

How has the IPC Lead role impacted the role of nurses?

At an organisational level, workforce challenges in the attraction and retention of aged care nursing staff continue to impact providers consistently meeting IPC Lead requirements. However, the evaluation found that the likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most former IPC Leads reportedly remaining in the aged care sector once leaving the IPC Lead role. In addition, integration of IPC into quality and risk systems, and generating a baseline knowledge of IPC among all staff is key to mitigating loss of corporate knowledge due to turnover of the IPC Lead role. Additional expertise (internal or external) and relevant resources are needed to support the IPC Lead role and aged care homes more broadly.

At the individual level, the IPC Lead role provided a valuable opportunity for aged care nurses to upskill and enable career progression in some instances.

RECOMMENDATIONS

The recommendations arising from the evaluation findings have been categorised into four themes, as discussed below. Table ES1 presents a summary of the recommendations and associated evaluation findings.

IPC Lead guidance

Lack of overarching guidance and variations in IPC Lead role working conditions provides an opportunity to formalise guidance and set expectations on the integration and use of the IPC Lead role to support and bolster the IPC capability of aged care homes.

Expectations of the IPC Lead role, objectives, and requirements to undertake the role (i.e. minimum dedicated time appropriate to the aged care home type

and size) need to be outlined to provide clarity and recognition of the value add of the IPC role. This would facilitate better integration of IPC in quality and risk systems and support development of baseline IPC knowledge across all staff in aged care homes.

See recommendations 1–4 in Table ES1.

IPC Lead support

The IPC Lead role can be further supported in future with tailored training modules that relate specifically to the aged care sector, and opportunities for ongoing professional development.

Embracing a whole of organisation approach to IPC would enhance the impacts of the IPC Lead role and mitigate staff turnover and loss of corporate knowledge. There is a need to identify relevant and appropriate IPC training for aged care staff to undertake with the aim of aligning to existing and relevant training in the health and aged care sectors, e.g. Australian Commission for Safety and Quality in Health Care (ACSQHC) aged care IPC resources and training. A role-based or tiered approach to education and training requirements is an effective approach to guiding organisational capability, used in both health and aged care sectors in Australia and overseas.

Providers are at differing levels of maturity in regard to IPC. Creating an escalation pathway to draw in external IPC expert advice and support when required is needed. Cross-sector support in IPC (health) mobilised in a regional approach has been used in other countries to provide IPC support and strategies to aged care.

See recommendations 5–7 in Table ES1.

EXECUTIVE SUMMARY

IPC Lead program design and funding

It is important that the IPC Lead role is recognised and valued in the sector in order to attract and retain nurses in the role. This can be achieved through mechanisms such as allowing dedicated time for IPC training, and use of continued professional development hours for IPC training. Exploration of financial incentives to undertake the role could also be considered.

See recommendations 8–11 in Table ES1.

IPC Lead impact (insights)

Data collection that provides information on the value and impact of the IPC Lead role is essential to provide an evidence base for the role. Continued engagement and communication of the importance of IPC more broadly (i.e. reducing impact of influenza, gastroenteritis, etc.) with family/carers/friends will maintain sector and community support for IPC activities more broadly.

See recommendations 12–14 in Table ES1.

settings would then occur in years 2–3. Note that several findings have informed more than one recommendation.

IMPLEMENTATION OF RECOMMENDATIONS

A staged approach across one to three years is suggested to action the recommendations. The IPC Lead Framework and position description represent the main priorities to address in order to provide clarity and set expectations to the sector. Improvement to and continued monitoring of the IPC Lead role delivery and impact along with exploration of potential financial incentives are also actionable within 12 months. An IPC Lead forum/community of practice presents an opportunity to gather feedback on the IPC Lead Framework and position description along with the IPC training needs of the sector. Use of the Aged Care Safety and Quality Commission (ACSQC) IPC Capability Survey followed by a review of other aged care

EXECUTIVE SUMMARY

Table ES1: Summary of recommendations and findings

RECOMMENDATIONS	FINDINGS
IPC Lead program guidance	
<ol style="list-style-type: none"> 1. An IPC Lead Framework should be developed to provide more direction to aged care home providers on the implementation and integration of the IPC Lead role to support IPC capability and practices in aged care homes. The framework should include: <ul style="list-style-type: none"> – Development of an escalation pathway to draw in external IPC expert advice and support when required. The existing local relationships/dynamics with public health system organisations should be leveraged and formalised where possible. – Guidance on the minimum FTE requirements to undertake the IPC Lead role (appropriate to the aged care home size and type) is required to enable the role to be used effectively and ensure business continuity in terms of access to IPC advice. – Dedicated time to undertake ongoing professional development in IPC – A stronger focus on consumer engagement. 2. An IPC Lead role description (integrated into existing aged care nurse description) should be developed to reflect the remit of the IPC Lead role in line with the IPC Lead Framework to promote consistency and provide role clarity. 	<ul style="list-style-type: none"> • Finding 1: A range of approaches is used in addition to the IPC Lead role to work towards compliance to the Aged Care Quality Standards including external IPC consultants and organisation IPC Leads. • Finding 5: With no overarching guidance, IPC Lead role working arrangements vary widely between facilities due to variations in aged care home size, location, resident profile, and the responsibilities allocated to the IPC Lead role. • Finding 6: The appointment of two IPC Leads offered continuity of advice and guidance for aged care homes. • Finding 7: Aged care homes with one or more IPC Leads reported similar challenges with undertaking the role (dedicated time, ongoing professional development, and support). • Finding 15: There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively. • Finding 19: There was a perceived lack of organisational support [aged care home provider] for the IPC Lead role. • Finding 29: Not enough time was dedicated to the IPC Lead role which has impacted aged care nurse commitment to other duties to varying degrees. • Finding 32: The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care.
<ol style="list-style-type: none"> 3. Guidance should be provided on the integration of the IPC Lead role and activity outputs such as audits and communication of new IPC information into governance structures (e.g. clinical quality and safety committee). 	<ul style="list-style-type: none"> • Finding 8: The IPC Lead is not solely responsible for directing management of an outbreak. Escalation protocols are enacted, and broader clinical governance teams collectively discuss and direct the actions required. Most aged care homes feel they now have adequate systems in place to respond quickly to an outbreak. • Finding 9: Vaccination (influenza, COVID-19), good clinical governance and overall workforce capability are also contributing factors to effective IPC. • Finding 33: The turnover in the IPC Lead role can translate to a loss in corporate knowledge of IPC unless the aged care home staff have a baseline knowledge of IPC that is integrated into quality and risk systems.

EXECUTIVE SUMMARY

RECOMMENDATIONS	FINDINGS
4. Objectives of the IPC Lead role should be re-framed and communicated to be about bolstering IPC capability and practices to manage all IPC issues and infectious diseases.	<ul style="list-style-type: none"> Finding 10: The IPC Lead role needs to be more proactive now and focus on IPC issues and practices more broadly. Finding 23: The provision of IPC guidance, support and practices should be delivered in a risk-based approach appropriate to the care setting and consumer profile.
IPC Lead support	
5. Consider an annual IPC Lead forum and/or regional community of practices to complement support platforms such as the Australasian College for Infection Prevention and Control (ACIPC) online aged care IPC forum planned. Align with sector bodies, agencies, and organisations such as ACQSC, ACSQHC, and VICNISS (Victorian Hospital Acquired Infection Surveillance System).	<ul style="list-style-type: none"> Finding 13: Consolidated information, resources, and access to expertise (including peer support) are suggested improvements along with recognition of the role through specified remuneration and dedicated time to conduct the role. Finding 14: There is a lack of formal peer-to-peer and/or expert support widely available for IPC Leads to access. Finding 20: A range of mechanisms exist to access external IPC supports, these are typically dependent on broader existing local relationships and arrangements. Finding 25: Access to IPC expertise and peer support was sought through communities of practice and better integration with the health sector and its support pathways. Finding 31: Additional expertise (internal or external) and relevant resources are needed to support the IPC Lead role and aged care homes more broadly.
6. Consider the development of targeted IPC modules (for the aged care home setting) for ongoing professional development purposes with a suggested focus on: <ul style="list-style-type: none"> End of life care Dementia and other cognitive impairment conditions Cultural awareness and considerations. 	<ul style="list-style-type: none"> Finding 18: There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices (which may be associated with cultural beliefs in some settings). Finding 21: The downstream impact of IPC practices on aged care home residents, their families, friends, and carers were reported by stakeholders to be largely felt in residents with dementia, other cognitive impairment issues, and end of life. Finding 22: Social connections and overall wellbeing are critical to maintain in applying IPC practices. Finding 26: Targeted training to supplement the core IPC training was suggested with a focus on aged care resident cohorts (e.g. dementia, palliative care) and a practical application to the aged care operational setting.
7. Consider identifying relevant and appropriate IPC training recommended for all aged care staff to undertake as a complementary measure to bolster IPC	<ul style="list-style-type: none"> Finding 11: A whole of organisation approach to IPC including stronger engagement with residents' families, carers and friends is required.

EXECUTIVE SUMMARY

RECOMMENDATIONS	FINDINGS
capability collectively in aged care homes (e.g. a role-based curriculum matrix).	<ul style="list-style-type: none"> Finding 16: There was a reported uplift in IPC capability through the IPC Lead role across all aged care home staff, including improved IPC governance and education/training. However there is continual learning and development required.
Program design and funding	
8. Suggest IPC Lead roles undertake CPD activities focused on IPC as part of ongoing professional development to undertaking the IPC Lead role. 9. Dedicated time to undertake ongoing professional development in IPC	<ul style="list-style-type: none"> Finding 24: Time to undertake regular ongoing training and professional development was widely suggested. Finding 28: The IPC Lead role was noted to have provided a valuable opportunity for aged care nurses to upskill and enable career progression and/or opportunities. Finding 30: Workforce challenges in the attraction and retention of appropriate and engaged aged care nursing staff continue to impact providers consistently meeting IPC Lead requirements.
10. Consider and explore if a financial incentive to implement the minimum IPC Lead role FTE is feasible as an alternative to potential additional round(s) of IPC Training Grants.	<ul style="list-style-type: none"> Finding 3: The proportion of aged care homes without an IPC Lead at any one time is more likely to be due to transition between IPC Leads rather than not being able to appoint one. Finding 15: There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively. Finding 19: There was a perceived lack of organisational support [aged care home provider] for the IPC Lead role to varying degrees stemming from tangible support to acknowledgement of the role. Finding 29: Not enough time was dedicated to the IPC Lead role and impacted aged care nurses' other duties to varying degrees. Finding 32: The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care.
11. Consider undertaking a risk assessment of other aged care settings to understand the risk profile and risk-based approach to IPC required and the potential adaptation and/or expansion of the IPC Lead role in aged care settings.	<ul style="list-style-type: none"> Finding 12: A risk-based approach to IPC capability and practice is appropriate to aged care services in community-based settings, however this represented an area of uncertainty and was suggested to need further consideration.

EXECUTIVE SUMMARY

RECOMMENDATIONS	FINDINGS
Program impact (insights)	
12. Expand the IPC Lead role data reporting to include the allocated FTE per IPC Lead role and AHPRA registration number to track implementation and movement of IPC capability in the aged care home sector.	<ul style="list-style-type: none"> No visibility of movement of IPC Leads in the sector (between aged care homes) including FTE
13. Consider using the ACSQC IPC Capability Survey as an ongoing IPC capability indicator for aged care homes and explore the opportunity for the ACSQC to distribute the survey results in a format to allow aged care homes to benchmark.	<ul style="list-style-type: none"> Finding 17: Residents' family members'/carers' perception of the residents' experience and quality of life is lower than residents, acknowledging this may have been influenced by a range of factors, which may include the impact of IPC practices.
14. Continue to monitor the Quality of Care Experience Aged Care Consumers (QCE-ACC) and Quality of Life Aged Care Consumers (QOL-ACC) indicators to identify any changes or trends that may be attributable to IPC practices in aged care homes.	<ul style="list-style-type: none"> Finding 18: There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices (largely stemming from cultural beliefs).

1 INTRODUCTION

1.1 BACKGROUND

The Department engaged Healthcare Management Advisors (HMA) to:

evaluate the effectiveness of the Infection Prevention and Control (IPC) Lead Nurse role and its impact during COVID-19 in Aged Care

The IPC capability of all health and human services systems faced the common challenge of responding to the COVID-19 pandemic, formally declared by the World Health Organization (WHO) as a Public Health Emergency of International Concern on 30 January 2020 (declared to be no longer on 5 May 2023). While significantly accelerated development of IPC practices and measures has occurred since the start of the pandemic, the vulnerability of older Australians in aged care homes was exposed during this period.

As a result of the impact of COVID-19 on aged care homes, a special report into COVID-19 and aged care was produced during the Royal Commission into Aged Care Quality and Safety in 2020. The report found that although most aged care homes believed they had appropriate and sufficient measures in place to deal with COVID-19, a majority were in fact not prepared for the highly infectious nature of the virus and that immediate support and [government] action was required. Six recommendations were made in the report, and all were subsequently endorsed by the Commonwealth. Recommendation five called for:

All residential aged care homes [to] have one or more trained infection control officers as a condition of accreditation. The

training requirements for these officers should be set by the aged care advisory body we [the Royal Commission] propose.

The review stated that IPC officers should act as dedicated infection control champions and found that similar concepts have been successfully implemented in overseas jurisdictions.

The Australian Government subsequently took steps to address the deficiencies in aged care provider IPC practices while ensuring a nationally consistent approach. A key component of this reform effort was the introduction of the IPC Nurse Lead (henceforth referred to as IPC Lead) which required all aged care homes to appoint an IPC Lead by 1 December 2020.

The IPC Lead role aims to increase infection prevention control expertise across the aged care sector and offers a focal point for ACQSC to audit aged care services regarding IPC capability.

1.2 PURPOSE AND STRUCTURE OF THIS DOCUMENT

This document (the IPC Lead Evaluation Report) provides a summary of the evaluation approach, findings, and key insights that have informed the development of evaluation recommendations.

The remainder of the document is structured into two parts as follows:

Part A - Context and evaluation approach

- **Chapter 2** presents a summary of the situation analysis
- **Chapter 3** presents a summary of the evaluation approach

1 INTRODUCTION

Part B - Evaluation findings

- **Chapter 4** presents a summary of the findings relevant to key evaluation area one (implementation)
- **Chapter 5** presents a summary of the findings relevant to key evaluation area two (appropriateness)
- **Chapter 6** presents a summary of the findings relevant to key evaluation area three (support)
- **Chapter 7** presents a summary of the findings relevant to key evaluation area four (impact)
- **Chapter 8** presents SWOT analysis
- **Chapter 9** presents a summary of the key findings, opportunities, and recommendations

Appendices

In addition, this document is supported by a technical paper that includes:

- IPC Nurse Lead case study visit guide
- IPC Nurse Lead evaluation ethics protocols
- IPC Nurse Lead Participant Information and Consent Form RACF
- IPC Nurse Lead Participant Information and Consent Form family carer friend
- IPC Nurse Lead Participant Information and Consent Form Residents
- IPC Nurse Lead resident family carer friend interview guide
- IPC Nurse Lead aged care provider consult guide (initial consultations to inform the situation analysis)
- IPC Nurse Lead stakeholder consult guide
- Previous IPC Nurse Lead survey synopsis
- Former IPC Lead survey questions
- Current IPC Nurse Lead survey synopsis
- Current IPC Lead survey questions
- IPC Nurse Lead Role Project information bulletin.

PART A

CONTEXT AND EVALUATION APPROACH

2 CONTEXT

This Chapter presents a summary of the IPC Lead role arrangements, policy, and issues.

2.1 POLICY AND ENVIRONMENTAL CONTEXT

The policy response to minimise the transmission of COVID-19 and its impact on aged care home providers, staff, residents and the community continues to evolve with pace since COVID-19 was declared a public health emergency of international concern by the WHO and added as a human disease to the Australian Biosecurity Act 2015. Measures were introduced to reduce the spread of the virus including social distancing, commercial trading restrictions, and stay-at-home orders with varying impacts on economic activity. Economic support for residential aged care included the establishment of the COVID-19 support supplement at a value of more than \$420 million; this money was distributed in June 2020 (\$205 million) and October 2020 (\$217.6 million) to aged care homes. This funding was provided to assist with COVID-19-related costs, including IPC Leads costs.

Figure 2.1 presents an overview of the policy and environmental context that has shaped the COVID-19 response in aged care homes. The commentary in grey captions above the timeline reflects the key events and broader COVID-19 policy responses. The commentary in yellow captions below the timeline reflects the key events and COVID-19 responses specific to residential aged care. The Australian Guidelines for the Prevention and Control of Infection in Healthcare along with the guiding statements of the Australian Health Protection Principal Committee (AHPPC) provided direction for both the healthcare and aged care sector in IPC practices. State and territory health authority advice and the Aged Care Quality Standards guided IPC practices more specifically to the residential aged care homes.

COVID-19

The most noticeable impacts were driven by two COVID-19 variants: the Alpha strain of the virus which arrived in Australia in January 2020, and the Delta strain which was first detected in June 2021. These triggered several rounds of restrictive measures and subsequent lockdowns, particularly in Victoria.

The COVID-19 vaccination program commenced in February 2021 which meant the nation had high vaccination rates when the Omicron variant was detected in November 2021. Despite the increasing rate of infection, federal and state governments did not introduce new lockdown restrictions and travel and trading restrictions were gradually eased.

The emergency pandemic measures ended in April 2022, with mandatory isolation periods for individuals testing positive for COVID-19 ending several months later in September 2022 – excluding those who work in health and aged care. The state of flux and level of uncertainty around health and socioeconomic risks gradually subsided, with longer-term vision and planning at the forefront of the ongoing response to the pandemic.

IPC capability in aged care homes

While IPC policies, guidelines and practices existed prior to COVID-19, specific to aged care homes and more broadly to the health sector, to mitigate outbreaks of infection (including influenza), the highly contagious nature of the COVID-19 virus highlighted broader systemic issues and the limitations of existing practices. Existing IPC practices at the start of the pandemic centred on the acute setting as noted by the **2021 Independent Review of COVID-19 outbreaks in aged care homes**.

2 CONTEXT

In mid-2020, the Royal Commission into Aged Care Quality and Safety conducted a special investigation of COVID-19 and the aged care system in Australia. One of the six recommendations made called for all residential aged care homes [to] have one or more trained infection control officers as a condition of their accreditation.

IPC resources

Online IPC training (face-to-face when required), information and surge workforce resources for aged care homes were provided by ACQSC and jurisdictional health authorities. IPC resources rapidly changed to reflect the steep learning curve of COVID-19 however, an unintended consequence of these support measures was the divergence of views and information provided to aged care homes.

The **Industry Code for Visiting in Aged Care Homes** was released in May 2020 to ensure the least restrictive IPC practices to balance the holistic wellbeing of residents.

On 31 August 2020, the Australian Government announced the second COVID-19 supplement was to be used by providers to fund and support enhanced infection control capability, including through an on-site clinical lead. Each aged care home was required to appoint an IPC Lead to support the development and implementation of IPC policies and procedures.

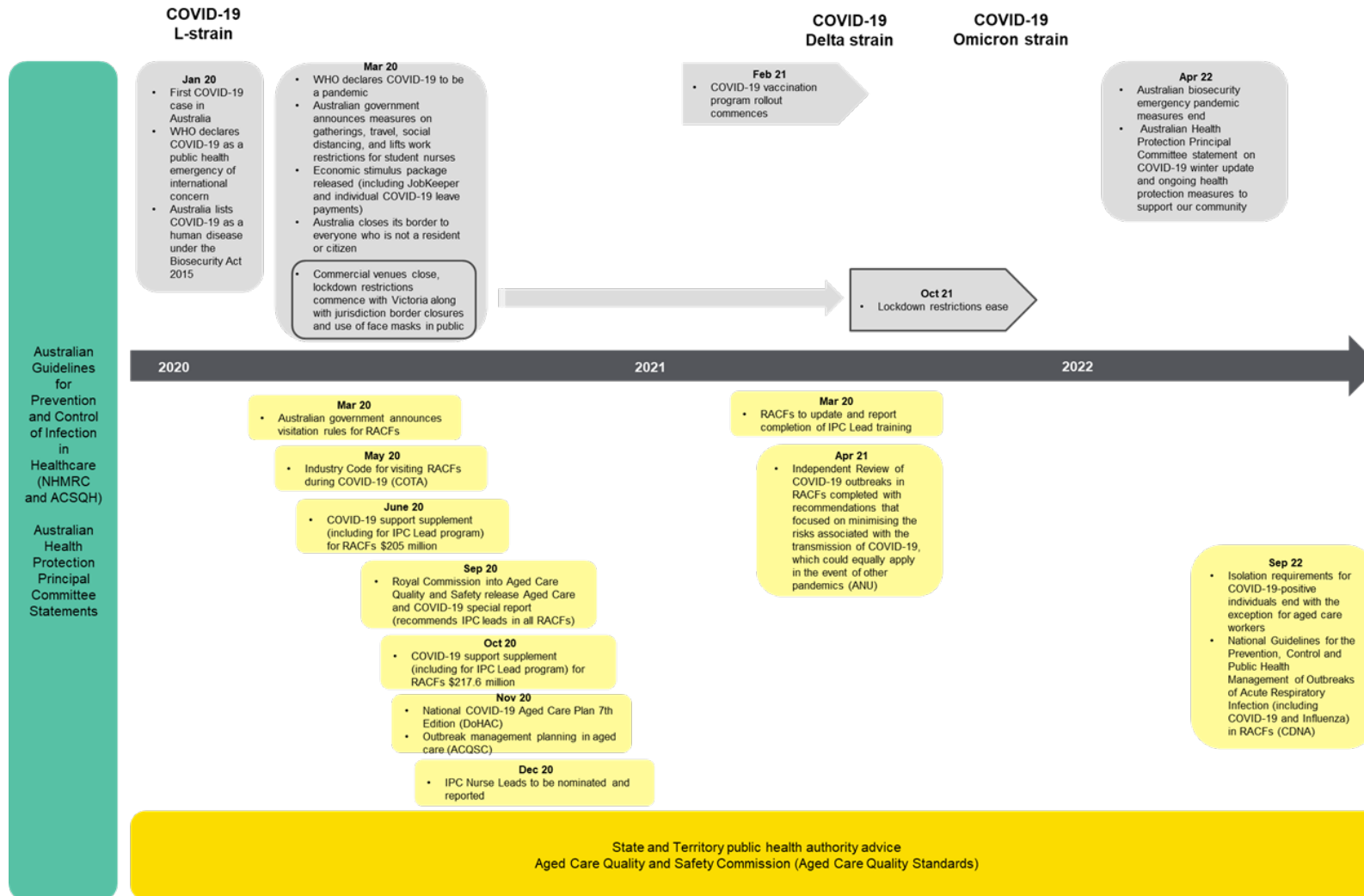
The **National COVID-19 aged Care Plan 7th Edition** was released in November 2020. This plan consolidated IPC learnings to date and aligned with the **Australian Health Sector Emergency Response Plan for Novel Coronavirus** to ensure consistency with the national health response to the pandemic. The ACQSC also released its **Outbreak management planning in aged care guidance**, designed as an overarching framework that incorporates references to other key documents and departments, relevant to preparing for and managing an outbreak effectively.

The Communicable Diseases Network Australia has developed national guidelines for the prevention, control, and public health management of outbreaks of acute respiratory infection (including COVID-19 and influenza) in residential aged care homes in Australia. These guidelines were endorsed in September 2022 by AHPPC and were developed in consultation with jurisdictions and the aged care sector.

The **Industry Code for Visiting in Aged Care Homes** was also subsequently updated in June 2023 to reflect current COVID-19 management practices with consideration of the **National COVID-19 Health Management Plan for 2023, National Statement of Expectations on COVID-19 management in aged care settings, and the National COVID-19 Community Protection Framework** (the COVID-19 Framework).

2 CONTEXT

Figure 2.1: Policy and environment context shaping the COVID-19 response in aged care homes



2 CONTEXT

2.2 IPC LEAD ROLE TRAINING AND SUPPORTS

The IPC Lead program is now underway with 96% of aged care homes reporting to have an IPC Lead [1]. The Aged Care IPC Training Grant (2022–23 government budget measure) was designed to provide support for more nurses in residential aged care to access IPC leadership training and ensure residential aged care services are well prepared to prevent or manage future infectious disease outbreaks including influenza and COVID-19. This grant closed on 30 June 2023. A range of IPC training options suitable for the aged care sector and health services are available across the Department, ACQSC and the Australian Commission on Safety and Quality in Health Care (ACSQHC); these include:

- COVID-19 aged Care Infection Control Online Training modules for approved aged care providers and employees of approved providers. This training is provided by ACQSC and covers the fundamentals of IPC for COVID-19 in aged care settings and is a requirement for all IPC Leads.
- IPC and hand hygiene training provided by ACSQHC – suitable for all aged care and healthcare workers, clinical or non-clinical as well as students.
- Infection prevention and control – advanced IPC modules provided by ACSQHC – suitable for IPC Leads, registered nurses (RNs), service managers and other staff responsible for IPC.
- Partnerships in care provided by ACQSC – suitable for partners, potential partners in care, or other visitors to aged care homes.
- IPC online resource library developed by ACQSC for aged care providers and staff.

In addition, the Commonwealth continues to provide support for Australian Government-funded aged care services (residential and in-home care) during COVID-19 outbreaks. This includes additional personal protective equipment, workforce support and cost reimbursements.

2.3 REGULATORY CONTEXT

Residential aged care providers have responsibilities under the Aged Care Act 1997 and the Quality of Care Principles 2014 for managing the quality of care they provide. The IPC Lead role is intended to support approved providers to meet these responsibilities as applied to IPC. ACQSC has responsibility for ensuring quality standards are adhered to by aged care homes, including for IPC practices.

Effective IPC practices in each aged care home are assessed by ACQSC under three of the eight Aged Care Quality Standards:

- Standard 3 – specifically Requirement (3)(g)
 - Minimisation of infection-related risks
- Standard 7 – specifically Requirement (3)(c)
 - The workforce is competent, and members of the workforce have the qualifications and knowledge to effectively perform their roles.
- Standard 8 – specifically Requirement (3)(c)
 - Effective organisation-wide governance systems
- Standard 8 – specifically Requirement (3)(e)
 - Where clinical care is provided – a clinical governance framework.

From 1 March 2020, ACQSC undertook targeted infection control monitoring visits in most residential aged care services across Australia. These visits involved monitoring IPC practices and service preparedness for COVID-19 outbreaks. Spot checks were also undertaken targeted specifically at COVID-19 preparedness. ACQSC reported a target of 1,200 spot checks for IPC practices in aged care homes in 2023, with approximately 900 completed to

2 CONTEXT

date (as of September 2023). ACQSC publishes a quarterly sector performance overview of aged care home indicators including:

- complaints about aged care services
- reportable incidents in residential aged care (e.g. unexpected death, inappropriate restrictive practices)
- sector performance against the Aged Care Quality Standards

Updates were made to the guidance and reflective questions by ACQSC to the Aged Care Quality Standards for the above Standards (3, 7 and 8) for providers in relation to the IPC Lead. The scope of the IPC Lead evaluation is contained to reviewing compliance against these Standards. It is important to note that Standard 5 also represents an area reflective of IPC practices:

- Standard 5 – specifically Requirement (3)(b)
 - The service environment
- Standard 5 – specifically Requirement (3)(c)
 - Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer

2.3.1 Aged care home consumer reporting requirements

All aged care homes are required to report positive cases of COVID-19 (residents, staff, and visitors) and COVID-19-positive resident deaths through the My Aged Care portal. In addition, aged care home providers must report data under the National aged Care Mandatory Quality Indicator Program (QI Program).

Consumer experience is currently captured through several mechanisms including the re-booted consumer experience interviews program – Resident Experience Surveys (RES). These interviews are conducted by an external party engaged by the Department. Providers are required to collect and report on consumer experience data and Quality of Life data from 1 April 2023 as part of the QI Program.

Noting there are no questions specifically relating to IPC practices, the existing survey and data may broadly be sensitive to the impact of IPC practices on residents and their families/carers and the perceived view of residents and their families/carers regarding aged care home staff knowledge and application of IPC practices.

2.4 CURRENT IPC LEAD ROLE ARRANGEMENTS

All aged care homes must have a dedicated on-site, IPC Lead as an ongoing requirement to support aged care homes to meet their IPC requirements under the Aged Care Quality Standards. This includes providers of the National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program and Multi-purpose service (MPS) Program.

An IPC Lead must be an RN or enrolled nurse (EN) and satisfy the following requirements:

- complete an approved IPC course along with completion of ACQSC's COVID-19 infection prevention and control online training (sits within ACQSC's learning management system)
- be employed by and report directly to the provider and
- work on-site and be dedicated to a residential aged care home.

IPC Leads may be an existing staff member and have a broader role in their aged care home beyond IPC responsibility. The function of an IPC Lead is to support the aged care home in the development and implementation of IPC procedures and observe, assess, and report on the IPC practices of the aged care home. An IPC Leads' working arrangements may vary between facilities due to variations in aged care home size, location, resident, and staff mix, and scope of services. The aged care home has autonomy to determine what level of engagement or workload is required of the IPC Lead to meet the required quality standards.

2 CONTEXT

2.4.1 IPC Lead training requirements and funding support

The IPC Lead program requires appointed nurses to complete a suitable training course that meets the following criteria:

- focus on IPC
- be specified at the level of AQF8
- be delivered by a recognised education or training provider, and
- has an assessment, or assessments, that facilitate successful completion of the course.

The training requirements for IPC Leads were set based on advice from AHPPC Aged Care Advisory Group. The following training courses have been identified as meeting the educational requirements of a suitable specialist IPC training course:

- Foundations of Infection Prevention and Control for aged Care Staff at ACIPC
- Graduate Certificate in Infection Prevention and Control, Griffith University
- Master in Infection Prevention and Control, Griffith University
- Graduate Certificate of Infection Control, James Cook University
- Graduate Certificate in Nursing Science (Infection Control Nursing), University of Adelaide

As of April 2023, most IPC Leads have completed and/or enrolled/commenced training with ACIPC (96.1%) [1].

Residential aged care providers were able to apply for funding through the Aged Care IPC Training Grant (which closed on 30 June 2023) to support RNs and ENs to complete specialist IPC Lead training. Financial support of \$13,020.00 per nurse, for up to two nurses (either RNs or ENs), was available per eligible residential aged care home. This funding is intended to subsidise costs relating to:

- fees for suitable IPC training courses

- wages for study leave, and
- wages for backfilling for nurses undertaking study.

Since 2016, service providers have been required to complete an annual Aged Care Financial Report that details sources of income including grants (recurrent and non-current) and expenses. Approved aged care service providers are also now required to submit the new Quarterly Financial Report from 2022–23.

2.4.2 IPC Lead program reporting requirements

Approved providers of residential aged care and MPS are required to report details of their IPC Lead nurse for each home through the My Aged Care provider portal. Required details include:

- the name of the IPC Lead
- the position they hold in the aged care home
- their nursing registration status
- completion status of ACQSC's COVID-19 online training modules
- details of their specialist qualification or of the specialist IPC training course they are undertaking.

Approved providers should ensure that information reported through the My Aged Care provider portal is updated when changes occur and kept up to date. In addition to this online reporting, approved providers are required to provide information about the expenditure associated with the IPC Lead program through reporting obligations linked to the Aged Care Financial Report.

NATSIFAC providers have a different reporting arrangement that requires them to use the IPC Lead notification form available on the Department's website because of IT challenges to access and upload via the My Aged Care portal.

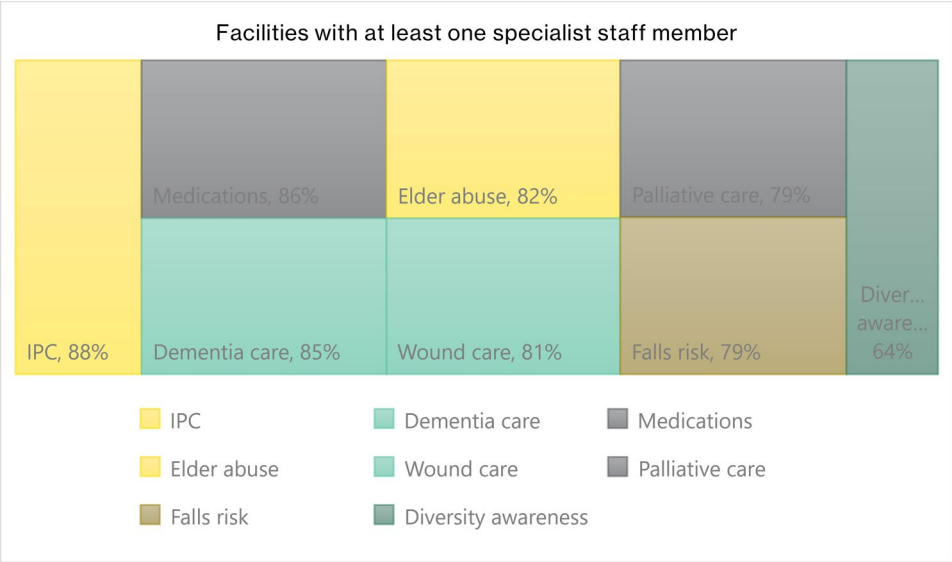
2 CONTEXT

2.5 NURSING WORKFORCE CONSIDERATIONS

The 2020 Aged Care Workforce Census Report [2] indicated most staff in aged care homes were direct care workers (75%). Nurses accounted for 23% of direct care workers, with personal care workers and allied health comprising 70% and 7% respectively. RNs represented approximately two-thirds (67%) of the nursing workforce in aged care homes followed by ENs (33%). Nurse practitioners represented less than 1% of the nursing workforce in aged care. IPC nurses accounted for the highest proportion of aged care homes that reported at least one staff specialist member, which is expected given the commencement of the IPC Lead training and additional online COVID-19/IPC training resources.

A range of other additional skills to provide specialist care support were reported, indicative of the range of training opportunities, and skillsets in aged care homes, presented in Figure 2.2.

Figure 2.2: Skills to provide specialist care support in Aged care homes



Source: Based on data from the 2020 Aged Care Workforce Census Report

Prior to the pandemic, the aged care sector faced staffing challenges including high levels of staff turnover and difficulty in attracting staff. This has been attributed to factors such as low remuneration and limited career paths (compared to nursing in acute and community-based healthcare settings in general). COVID-19 has added to these challenges. Workforce attrition over the 12 months from November 2019 to November 2020 was reported in the Census Report to be 37% for both nurse practitioners and RNs, and 28% for ENs (the average was 29% for all direct care workers). [2] While the healthcare sector offers greater career pathway diversity and opportunity (along with higher salary opportunities), it too faces workforce challenges associated with an ageing population and ageing workforce, leading to high competition for nurses across health sectors. Health Workforce Australia estimates that there will be a shortage of over 100,000 nurses by 2025 and

2 CONTEXT

more than 123,000 nurses by 2030. Nursing workforce shortages in rural/remote areas are also an issue of ongoing concern.

To help address these challenges, the Australian Government is supporting nurses to enter and build their careers in the aged care sector through the provision of scholarships, transition programs, and clinical placements available to nurses. The current supports available for nurses to access include:

- Aged Care Registered Nurse's Payment – payments for either 6 months or 12 months of employment will be available to RNs who work for the same aged care provider over the eligibility periods, up to a total of \$6,000.
- Transition to Practice Program – supports new aged care nurses with specialist training in aged care and gerontological nursing along with mentorship from senior aged care nurses.
- Aged Care Nursing Scholarship Program – available to nurses studying a graduate certificate, graduate diploma, or master's degree relevant to the care of older people and leadership and management.
- Clinical Placements – Bachelor and Master of Nursing students can receive support to gain high-quality clinical placements in the care and support sector including:
 - Aged care
 - Veteran's care
 - Disability support

2.6 RECENT EVIDENCE ON BEST PRACTICE APPROACHES TO IPC IN AGED CARE HOMES

The Department recently commissioned the Australian National University to conduct the rapid review: *Effective prevention and management of COVID-19 in aged care settings: a commissioned rapid review of international evidence*. The Department has recently used this review to inform other work, however, it is not yet publicly available.

A literature scan of recent evidence on IPC practices in aged care facilities revealed that most of the recently completed research on this topic is made up of retrospective studies on the various strategies used to manage the COVID-19 pandemic and the impact or outcomes of COVID-19-related deaths and transmission on IPC practices.

An international review of social distancing and isolation strategies to prevent and control the transmission of COVID-19 and other infectious diseases in care homes [3] found there was a lack of empirical evidence to support this measure as an effective strategy in aged care homes. Several long-term care homes in France were highlighted to have lower mortality related to COVID-19 among residents and lower incidence of COVID-19 among residents and staff members than rates recorded in a national survey through voluntary self-confinement of nursing home staff members [to the aged care home] with residents. This measure was confined to the pandemic wave in 2020 only. These interventions were generally mentioned as part of broader COVID-19 strategy reviews and were not the focus of the studies.

Several factors were identified in the research as supporting aged care homes to implement interventions to control the transmission of COVID-19 and other infectious diseases. These included access to innovative technology; clear communication with residents and families; and ensuring staff were sufficiently trained and supported.

Netherlands and Denmark have been recognised as the countries with the 'best practices' for COVID-19 IPC in long-term care facilities (aged care homes) [4]. It noted that investment in health and social care systems was important for well-integrated and well-resourced systems, which both Netherlands and Denmark had addressed prior to COVID-19. IPC practices in

2 CONTEXT

the Netherlands use ‘cohort nursing’ and ‘nurse cohorting’¹ along with a centralised allocation of personal protection equipment via a single new national consortium. Denmark’s IPC practices include single rooms with home-like living spaces in all modern nursing homes and customisation of visitor policies. Cohorting may also be used to segregate residents.

The profile of residents living in aged care homes includes those with cognitive impairment such as dementia. Additional challenges in the implementation of IPC measures were highlighted in this cohort. A prospective US study looking at dementia and COVID-19 infection control in assisted living facilities reported that dementia-specific facilities experienced more challenges in the implementation of IPC measures (mask wearing, social distancing) [5].

A comparison of aged care home IPC practices in other OECD countries was undertaken (a summary table of the findings is presented in Appendix A). The

analysis showed that key IPC practices such as visitor screening/restrictions, hand hygiene, PPE protocols, social distancing and staff training in IPC practices were common elements of IPC across these jurisdictions. In addition, aged care facilities in OECD countries were found to be monitored by the authority responsible for oversight of aged care. However, outcome indicators were limited to positive cases of COVID-19 (residents and staff) and related deaths. Compliance with relevant standards/guidelines was found to be based on qualitative compliance assessment. European countries (Denmark, France, Netherlands) utilise regionalised IPC networks and centres to support aged care facilities. Denmark and the Netherlands look to aged care home design to enable segregation or cohorting. This practice was also noted by the Australian Independent Review of COVID-19 in aged care homes as an effective IPC control. Australia, England (UK) and Canada also utilise IPC practitioners (nurses with a formal qualification in IPC) or leads (Ontario) to aid IPC implementation and practice in aged care facilities.

¹ Cohorting refers to practices of sectioning the workforce to a particular facility, area of a facility and/or to residents who have tested positive for an infectious disease. In Australia resident

cohorting can be used to minimise transmission and spread of infectious diseases only, not for prevention.

3 EVALUATION APPROACH

3.1 OVERVIEW

The evaluation assessed the introduction of the IPC Lead role on IPC capability in aged care homes with a focus on:

- implementation
- perceived benefits and experiences of the aged care sector and service users
- drivers and support for the IPC Lead to undertake their role
- integration and alignment with the Australian Aged Care Quality Standards and other relevant guidelines
- awareness, knowledge, and adoption of IPC practices in aged care homes.

The evaluation examined the intended aims and outcomes of implementing IPC Lead roles in aged care homes. The evaluation assessed changes in IPC capability in aged care homes with a lens on IPC policies, procedures, practices, and continuous improvement within the service.

In addition, the sustainability and currency of the IPC Lead role program was considered. The implementation of the IPC Lead role by providers was reviewed to identify any variations along with factors relating to the training, education, and broader sector support for the role.

3.2 METHOD

The evaluation applied a mixed methods approach with quantitative and qualitative data informing the analysis and responses to the evaluation questions. The evaluation was undertaken in a staged approach, culminating in a Final Report due 4 December 2023. Key tasks included:

- Stage 1: Project initiation and planning
- Stage 2: Situation analysis
 - desktop review of existing program documentation and data
 - literature scan on IPC practices and comparable international programs
 - Evaluation framework development.
- Stage 3: Data infrastructure development and ethics
 - Development of stakeholder discussion guides, and case study visit guide
 - Development of the IPC Lead surveys for current and former IPC Leads:
 - An IPC Lead survey for former IPC Leads was disseminated for six weeks via the Australasian College for Infection Prevention and Control (ACIPC). There were 167 survey respondents, however approximately 22% were still in the role.
 - An IPC Lead survey for current IPC Leads was disseminated via the Department's aged care sector newsletter for a period of six weeks, with 155 respondents.
 - Development of data specification requests:
 - ACQSC data related to IPC including (see Appendix B for further details on the data analysed):
 - IPC Capability Survey disseminated to all aged care home providers in 2023
 - IPC-related complaints made to ACQSC 2019/20 to 2022/23

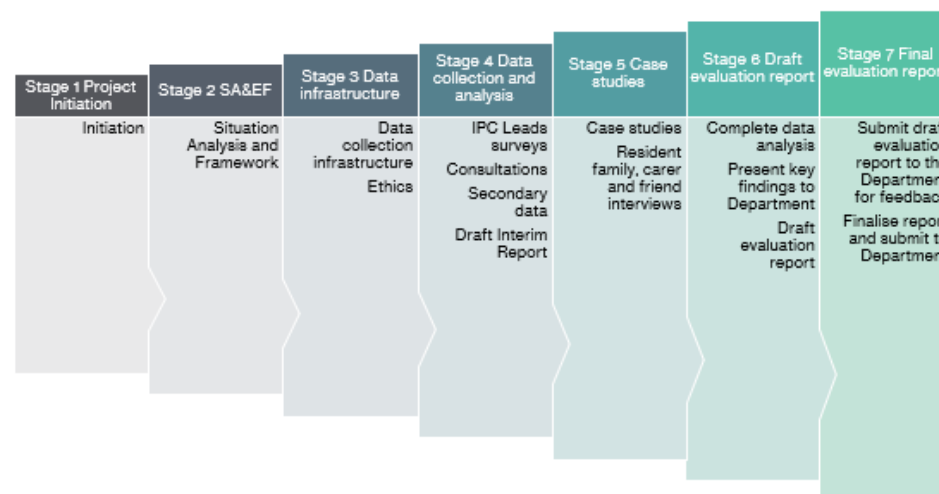
3 EVALUATION APPROACH

- Instances of non-compliance and compliance with Standards 3 (3)(g), 7 (3)(c), and 8 (3)(c) over financial years 2019/20 to 2022/23
- IPC Lead program data:
 - IPC Training Grant request data
 - Analysis of IPC Lead implementation coverage (undertaken by third-party Quantum)
- Ethics application approved by Bellberry HREC and WA Country Health Service ethics (specific to WA MPS sites only).
- Stage 4: Data collection (stakeholder consultation)
 - Consultations with key aged care sector stakeholders were undertaken to understand the benefits of the IPC Lead role, factors affecting the implementation and delivery of the IPC Lead program, and the sustainability and impact of the program. The findings were analysed to develop an interim evaluation report presenting preliminary findings. Refer to Appendix C for list of stakeholders consulted.
- Stage 5: Case studies
 - Case study visits were undertaken with 20 aged care homes across Australia. Selected aged care homes included a mix of provider type (government, not-for-profit, and for-profit), geography (state/territory and remoteness), aged care home size, and scope of service offering (refer to Appendix D for case study site selection criteria and sample frame). A sample of six family/friends/carers from six aged care homes consented and participated in an interview to discuss their experience of IPC in the aged care home.
 - IPC Lead coverage data indicated a number of for-profit aged care homes in metropolitan areas with no IPC Leads. However, if the sample frame of for-profit aged care homes registered with no IPC Lead, none intentionally had no IPC Lead. All were reportedly in transition between leads and/or newly opened and had now

implemented one. Two additional aged care homes were engaged to be a case study site for breadth.

Figure 3.1 presents an overview of the evaluation approach.

Figure 3.1: Evaluation approach



3.2.1 Supporting documentation

The key project artefacts are included in the Appendix of the Final Report (this document). All other project artefacts have been collated into an accompanying technical paper and include:

- IPC Nurse Lead case study visit guide
- IPC Nurse Lead evaluation ethics protocols
- IPC Nurse Lead Participant Information and Consent Form Residential Aged Care Facility
- IPC Nurse Lead Participant Information and Consent Form family carer friend

3 EVALUATION APPROACH

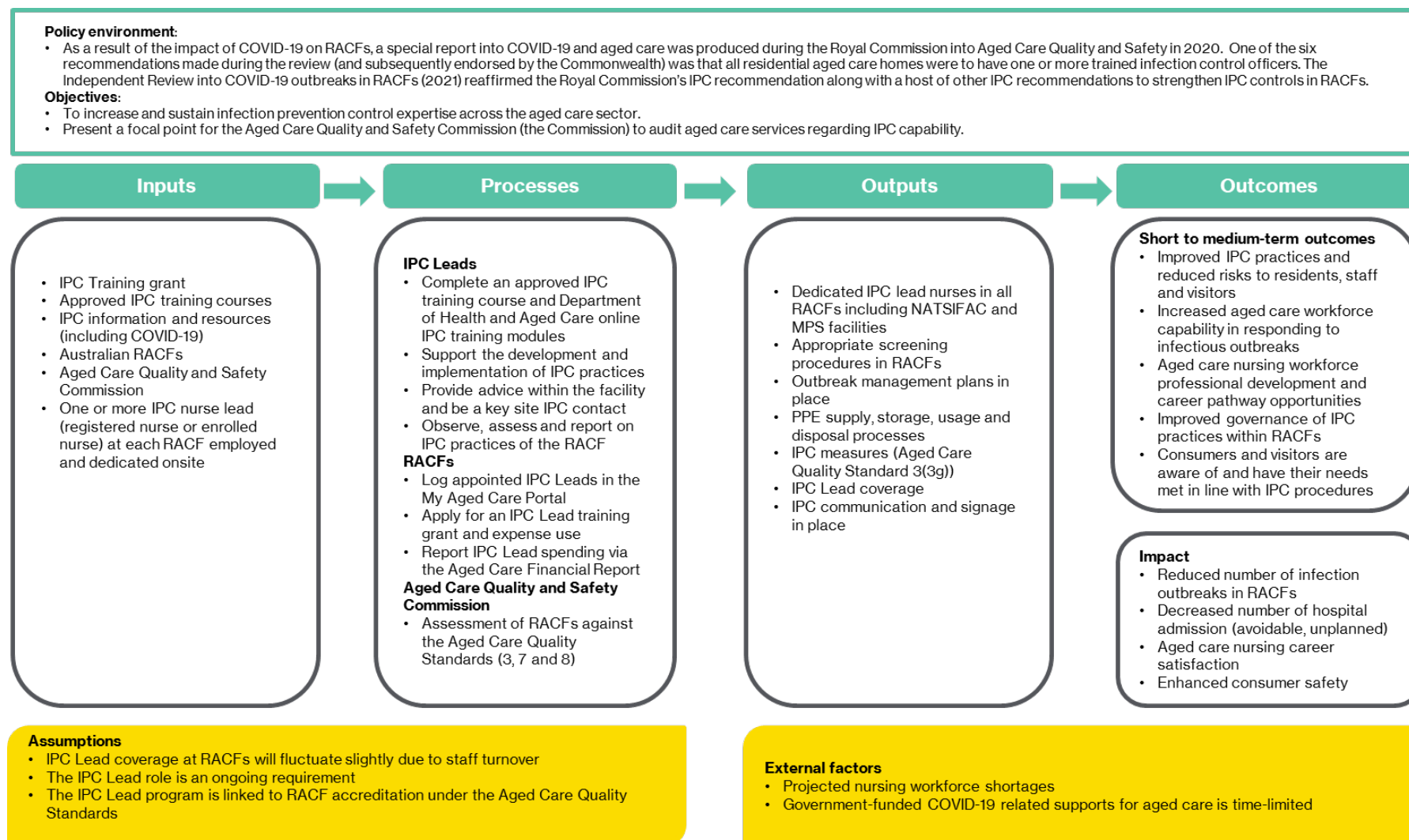
- IPC Nurse Lead Participant Information and Consent Form Residents
- IPC Nurse Lead resident family carer friend interview guide
- IPC Nurse Lead aged care provider consult guide (initial consultations to inform the situation analysis)
- IPC Nurse Lead stakeholder consult guide
- Previous IPC Nurse Lead survey synopsis
- Former IPC Lead survey questions
- Current IPC Nurse Lead survey synopsis
- Current IPC Lead survey questions
- IPC Nurse Lead Role Project information bulletin

3.3 PROGRAM LOGIC

Figure 3.2 on the following page provides the program logic for the IPC Lead role evaluation. It was informed by review of program documentation, relevant peer-reviewed literature, and consultation with the Department.

3 EVALUATION APPROACH

Figure 3.2: IPC Lead program logic model



PART B EVALUATION FINDINGS

4 KEA 1: IMPLEMENTATION

This chapter focus on KEA 1: Implementation of the IPC Lead role; it explores **how well the IPC Lead role has been implemented by aged care homes and the suggested improvements.**

KEY INSIGHTS

Summary:

- While the IPC Lead role includes the purpose of being the point of contact for ACQSC audits and Infection Control Management spot checks, providers use a range of approaches to work towards compliance to the Aged Care Quality Standards, including the use of external IPC consultants.
- There is consensus that the IPC Lead role aligns with and contributes to meeting the Aged Care Quality Standards, however there is suggested room for improvement in the Standards themselves.
- IPC principles are the same for both health and aged care, however, the application of IPC practices differs by operational setting such as aged care homes.
- There is limited formal integration and/or relationships between the service sectors (e.g. health), and it is usually dependent on existing local relationships and arrangements for aged care home service providers.
- The proportion of aged care homes without an IPC Lead at any one time is more likely to be as a result of transition between IPC Leads rather than taking a position to not appoint one. The largest proportion of aged care homes by setting without an IPC Lead are in remote or rural settings.

- With the continued transition in IPC Leads and the implementation of additional IPC Leads, funding for IPC training was suggested to still be needed to minimise costs incurred to aged care homes.
- The IPC Lead role function is to aid the management of outbreaks of Covid-19 and increasingly of other communicable diseases, and aid with implementing and training aged care staff in IPC practices.
- With no overarching guidance, IPC Leads working arrangements vary widely between facilities due to variations in aged care home size, location, resident profile, and allocated responsibilities to the IPC Lead role.
- The appointment of at least two IPC Leads offered continuity of advice and guidance for aged care home/s.
- Aged care homes with one or two or more IPC Leads reported similar challenges with undertaking the role (the volume of dedicated time for training and performing the role, ongoing professional development, and support).
- While it is likely to be highly beneficial to have an IPC Lead role, other complementary factors, such as vaccination (influenza, COVID-19), good clinical governance and overall workforce IPC capability are also contributing factors to effective IPC.
- The IPC Lead is not solely responsible for directing management of an outbreak. Escalation protocols are enacted, and broader clinical governance teams collectively discuss and direct actions required. Most aged care homes feel they now have adequate systems in place to respond quickly to an outbreak.
- The IPC Lead role needs to be more proactive and focus on IPC issues and practices more broadly to respond to future threats.
- A whole of organisation approach to IPC is required including stronger engagement with residents' families, carers and friends.

4 KEA 1: IMPLEMENTATION

- A risk-based approach to IPC capability and practice is appropriate to aged care services in community-based settings, however this represented an area of uncertainty and was suggested to need further consideration.
- The selection of an aged care nurse able to commit and fulfil the required training and activities of the IPC Lead role was highlighted to be essential.
- Consolidated information, resources, and access to expertise (including peer support) were suggested improvements along with recognition of the role (remuneration, dedicated time).

KEA 1 QUESTIONS

The key evaluation questions to be addressed under KEA 1: Implementation are as follows:

1. To what extent does the IPC Lead role align with the Aged Care Quality Standards (the Quality Standards)?
 - Have the expectations of the IPC Lead role in the Quality Standards been met?
 - How well does the IPC Lead role work within the regulatory framework ACQSC uses to monitor aged care services?
 - How successful has the role been in integrating with and complementing other health services and aged care programs?
2. How thoroughly has the IPC Lead role been utilised in residential aged care?
 - What are the differences in the way the IPC Lead role has been implemented (including in FTE allocation, provision of other supports etc.)?
 - What impacts did variations in the number of IPC Leads per aged care home have?

3. To what extent does the IPC Lead role assist outbreak management in aged care homes?
4. What opportunities for improvement exist?
 - Can the IPC Lead role be modified to ensure safer care for residents of residential aged care services?
 - How could the IPC Lead role be modified to support providers of other aged care services such as home care, and flexi care?
 - What are the lessons from the introduction of the IPC Lead role?

ANALYSIS AND FINDINGS

4.1 ALIGNMENT OF THE IPC LEAD ROLE WITH AGED CARE QUALITY STANDARDS

Consultation with stakeholders and discussions with aged care homes indicated that the IPC Lead role was a useful resource for undertaking activities to meet the Aged Care Quality Standards (relevant to IPC), such as completion of IPC audit checklists. Aged care homes also felt the IPC Lead role was a resource to keep abreast of IPC practices and provide advice to achieving compliance with the Aged Care Quality Standards, as well as minimise the impact of outbreaks on residents.

It was noted that some aged care homes still preferred to engage external IPC consultants to draw in current independent expert advice and training, and as an additional resource.

The Aged Care Quality Standards relating to IPC have been adapted from IPC standard in the healthcare setting (National Safety and Quality Health Service Standards [6]). Although IPC principles apply across health and aged care, IPC Leads, and aged care staff indicated that implementation of IPC was different in aged care homes compared to the hospital setting. A point of

4 KEA 1: IMPLEMENTATION

difference was noted in aged care homes auspiced by public health services [state government health owned] though, with reported alignment of the IPC Lead role to health IPC nurse consultants. On the basis of these differences, several stakeholder groups suggested changes to the Aged Care Quality Standards that better reflect IPC practices and requirements in the aged care home would be beneficial.

Several aged care homes also suggested the current mandatory regulatory reporting requirements (e.g. QI Program, Serious Incident Response Scheme, notifiable disease reporting (influenza, COVID-19, gastroenteritis)) to be onerous with limited feedback or opportunity to benchmark.

Survey response from current IPC Leads indicated most (84%) felt the role aligned with the Aged Care Quality Standards and broader aged care regulatory context (moderately to extremely well). However alignment with IPC practices in other aged care programs was an area of uncertainty with only half reporting alignment (moderately to extremely well) and 39% were unsure. Similarly while 64% of respondents felt the role aligned with IPC practices in healthcare services, 26% were unsure of the alignment. Limited feedback from respondents indicated that while IPC Lead role activities may aid in achieving regulatory compliance [to Aged Care Quality Standards], there was the perception that IPC measures don't fully align with the Standards, the role has little impact, and there is still a place for expert IPC consultancy services. Measures to understand the success of the role in this context were also suggested.

A third-party provide a monthly online forum/training session in infection and prevention for our aged care home/provider

While there is a degree of consensus that the IPC Lead role aligns with and contributes to meeting the Aged Care Quality Standards, there is room for improvement in the Quality Standards themselves to align with the aged care home setting more.

Quality systems were highlighted by stakeholders and aged care homes to be a key requirement to effectively drive quality care. IPC is not the responsibility of one person but rather a whole of organisation approach and responsibility.

- | | |
|-----------|--|
| FINDING 1 | A range of approaches are used in addition to the IPC Lead role to work towards compliance to the Aged Care Quality Standards including external IPC consultants and organisation IPC Leads. |
| FINDING 2 | There is consensus the IPC Lead role aligns with and contributes to meeting the Aged Care Quality Standards, however there is room for improvement in the Quality Standards themselves. |

4.2 IPC LEAD UPTAKE AND IMPLEMENTATION

Analysis of the IPC Lead program data indicated that as of May 2023, over 96% of aged care homes (of a total of 2,671 aged care homes in Australia) had appointed an IPC Lead [1].

The attrition and turnover in the aged care nursing workforce results in the proportion of aged care homes with an IPC Lead fluctuating between 95 to 100% with variation across points in time. The proportion of aged care homes without an IPC Lead at any one time is more likely to be attributed to transition between IPC Leads rather than taking a position to not appoint one.

Although aged care providers were required to appoint and report an IPC Lead role in the My Aged Care Portal by 4 December 2020, over half of NATSIFAC providers did not report an IPC Lead (56.8%) [1]. This may be attributed to a separate reporting process; IT challenges mean some NATSIFAC providers are unable to report through the My Aged Care portal and must use an alternate form submission process. In addition, no IPC Lead was reported for 21.1% of remote providers; however, this was likely a result of a high proportion of NATSIFAC facilities being in remote areas [1]. At least one IPC Lead role had been implemented in most (62%) MPS sites as of

4 KEA 1: IMPLEMENTATION

August 2023 with 10% not yet reporting an IPC Lead role [7]. Only 2–3% of aged care homes located in MM² 2–5 settings had not yet reported an IPC Lead role, with 17% in MM 6 [7].

However, in undertaking the data screening process to identify and invite aged care homes with no IPC Lead to participate as a case study in the evaluation, no homes were identified that intentionally had no IPC Lead. All homes identified through the reporting data as having no IPC Lead reported being in transition between IPC Leads and/or were newly opened and had recently implemented an IPC Lead within the workforce at the time of being contacted for participation.

Nearly 40% (969) of aged care homes submitted at least one application for the IPC Training Grant round ending June 2023. Each aged care home submitted a range of one to four applications (mean 1.5, median and mode of one) for an RN or EN to complete an approved IPC training course. Of the 1,488 individual applications, 1,460 applied for both study leave and backfill in addition to the course fees. Applications totalled more than \$11 million with an average of \$7,409 per application. With the continued turnover in IPC Leads, several aged care homes suggested funding for IPC training was still needed to minimise costs incurred to aged care homes.

Survey responses indicated the types of support provided by IPC Leads largely related to assistance during outbreaks (77%), and training/coordination of IPC training for aged care home staff (73%). Similarly case study sites reported sustainable capacity to manage outbreaks was a key driver to implement the IPC Lead role effectively. Minimisation of sick leave absences and isolation periods was also noted to be an important driver in reducing the impact on the workforce. Particularly critical in remote locations with far less access to the workforce. Being the aged care home point of contact for ACQSC (61%) and implementation (48%) of policies and protocols were also reported by survey respondents. The development of policies and protocols was reported to a lesser degree of 25%, likely

attributable to aged care homes developing policies and protocols at the organisation level for consistency.

Nearly 80% of respondents also felt the IPC Lead role had been used moderately to extremely well with most (90%) seeing the role as important to continue (moderately to extremely important).

FINDING 3	The proportion of aged care homes without an IPC Lead at any one time is more likely to be in transition between IPC Leads rather than taking a position to not appoint one.
FINDING 4	The IPC Lead was largely reported to prepare for and provide assistance during outbreaks and assist with IPC training of aged care staff.

4.2.1 Variation in implementation of the IPC Lead role

IPC Leads working arrangements may vary between facilities due to variations in aged care home size, location, resident and staff mix, and scope of services. The aged care home determines the level of engagement or workload required of the IPC Lead role to meet the required quality standards.

There is no overarching guidance on the required number of FTE of IPC Leads based on the size and scope of services of aged care home. This is reflected in the wide range of FTE allocated to the IPC Lead role as reported during this evaluation. Respondents to the IPC Lead surveys reported a wide range of FTE allocated to the IPC Lead role ranging from nil to 1.0 FTE, with an average of 0.4, a median of 0.2 (0.3 current IPC Leads) and a mode of 0.1.

Analysis of the IPC Lead program data indicated that the average number of IPC Leads per aged care home is 1.4 (as of April 2023) [1]. Aged care homes

² MM refers to the [Modified Monash Model](#) which measures remoteness and population size on a scale of Modified Monash (MM) categories MM 1 to MM 7. MM 1 is a major city and MM 7 is very remote.

4 KEA 1: IMPLEMENTATION

with a higher number of residents (over 100) were more likely to have multiple IPC Leads. However aged care homes smaller in size and/or in a MM 2–7 setting also reported the need for IPC expertise to be available at all times (i.e. more than one IPC Lead was needed) as outbreaks can occur at any time. The escalation pathways for outbreak management also varied by aged care provider and type.

Various approaches to the implementation of the IPC Lead include:

- Appointment of aged care home management roles as the IPC Lead based on the higher likelihood of staff retention.
- Appointment of two or more RNs or ENs to provide professional development opportunities.
- Appointment of two or more RNs or ENs for succession planning purposes (i.e. to account for staff turnover).

Typically the aged care home management completed the IPC Lead training to provide support and leadership to the aged care home and any other IPC Leads. However, the burden of additional responsibilities was not sustainable for one person as the aged care home manager as well. The clear advantage with two or more IPC Leads was continuity of business (availability of IPC advice and guidance, particularly during an outbreak).

FINDING 5 With no overarching guidance, IPC Lead roles working arrangements vary widely between facilities due to variations in aged care home size, location, resident profile, and allocated responsibilities to the IPC Lead role.

FINDING 6 The appointment of two IPC Leads offered continuity of advice and guidance for aged care homes.

4.2.2 Impacts from the implementation of different numbers of IPC Leads

It is difficult to draw a comparative analysis on the impacts from the implementation of different numbers of IPC Leads in aged care homes.

Aged care homes with one or two or more IPC Leads reported similar challenges with undertaking the role (dedicated time, ongoing professional development and support). Several aged care homes that implemented the aged care home manager as IPC Lead had subsequently or were in the process of looking to implement another IPC Lead role to increase coverage and alleviate workload.

Data insights from IPC Capability Survey revealed the relative risk³ of having an influenza outbreak if no IPC Lead to be a 1.6 increased risk. The relative risk of having a gastroenteritis or COVID-19 outbreak was decreased (0.8) or no effect (1.0) respectively. However, the 'relative risk of outbreaks if no IPC Lead' is based on a sample frame containing proportionately very few aged care homes with no IPC Lead (refer to Appendix B). These results are broadly indicative and represent a snapshot in time only. It is also worthwhile noting that COVID-19 appears to be contagious for a longer time and can spread more quickly than influenza [8]. Similarly, viral gastroenteritis (caused by the rotavirus or norovirus) is highly contagious [9].

While it is likely to be highly beneficial to have an IPC Lead role implemented, vaccination (influenza, COVID-19), good clinical governance and overall workforce capability are also contributing factors to effective IPC.

- Vaccination: survey respondents reported 74.4 % and 89.2% of staff were up to date with influenza and COVID-19 respectively, as well as 86.2% and 82.5% of residents [respectively].

³ Relative risk is the ratio of the risks for an event for the exposure group to the risks for the non-exposure group. Thus relative risk provides an increase or decrease in the likelihood of an event based on some exposure.

4 KEA 1: IMPLEMENTATION

- Clinical governance: 99.8% of survey respondents had processes in place for checking that staff are using PPE where required and using the PPE correctly.
- Workforce capability: 99.7% of survey respondents reported that staff had been provided with training on infection, prevention, and control.

FINDING 7 Aged care homes with one or more IPC Leads reported similar challenges with undertaking the role (dedicated time, ongoing professional development, and support).

4.3 OUTBREAK MANAGEMENT

Aged care homes reported that the function of IPC Lead roles in managing outbreaks of infectious disease is dependent on structured preparation (training of aged care staff in outbreak management, planned protocols for management) and communication of actions required during an outbreak. It is important to note that the IPC Lead is not solely responsible for directing the management of an outbreak (with the exception of smaller facilities where the manager is the IPC Lead). Escalation protocols (as per outbreak management plans) are enacted and the broader governance team collectively discuss and direct the actions required.

An outbreak committee is stood up to discuss and direct actions required (consists of Director of Nursing, aged care home manager, IPC Lead)

Several aged care homes described IPC practices and outbreak management plans/kits to be in place prior to COVID-19/implementation of IPC Lead role; however, these had been reviewed and strengthened as part of the implementation of the IPC Lead role.

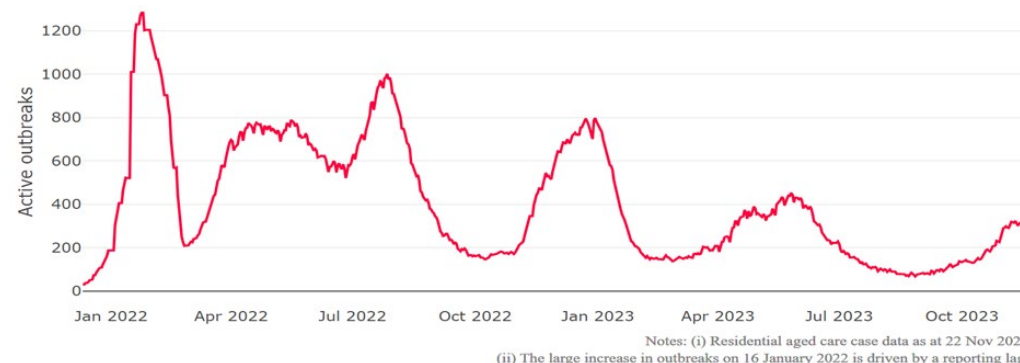
Similarly, nearly 70% of aged care home respondents to the ACQSC IPC Capability Survey rated their readiness in the event of an influenza, COVID-19 or gastroenteritis outbreak as 'best practice'. With nearly 31% of respondents

rating their readiness as 'satisfactory' (30.3%) or in need of improvement (0.5%), this suggests most aged care homes feel they now have adequate systems in place to respond to an outbreak. This aligns with the 99.8% of respondents who also reported an outbreak management plan to be in place (94.2% reviewed within the last 12 months).

The readiness of aged care homes to effectively prevent and respond to outbreaks was put to the test during the COVID-19 pandemic. Instances of non-compliance with the Aged Care Quality Standards 3 (3 (g)), 7 (3 (c)), and 8 (3 (c)) were reviewed across the four financial years 2019–20 to 2022–23 (see Appendix B). Instances of non-compliance increased in 2020–21 and 2021–22 during the height of the COVID-19 pandemic, before decreasing again in 2022–23 to levels below or close to 2019–20. This is not unexpected and likely reflective of the period of IPC capacity and supports building. Noting however that these results are broadly indicative only, as a mix of audit activities and services audited during 2020–22 were targeted and prioritised based on relative risk.

With the introduction of vaccinations, anti-viral medications, and more stringent IPC measures, the number of active outbreaks in aged care has decreased significantly across the last two years (Figure 4.1).

Figure 4.1: National outbreak trends in aged care



4 KEA 1: IMPLEMENTATION

Source: Australian Government Department of Health and Aged Care COVID-19 outbreaks in Australian residential aged care facilities 24 November 2023

- FINDING 8** The IPC Lead is not solely responsible for directing the management of an outbreak. Escalation protocols are enacted, and broader governance teams collectively discuss and direct actions required. Most aged care homes feel they now have adequate systems in place to respond quickly to an outbreak.
- FINDING 9** Vaccination (influenza, COVID-19), good clinical governance and overall workforce capability are also contributing factors to effective IPC capability.

4.4 OPPORTUNITIES TO ADAPT

4.4.1 Modification of the IPC Lead role in aged care homes

There was a consensus among stakeholders, aged care homes and IPC Leads that the IPC Lead role needs to be more proactive and focus on IPC issues and practices more broadly, including infectious disease other than COVID-19. Revised messaging to the sector on this point was suggested to continue the momentum of good IPC practices such as antimicrobial stewardship. Communication from ACQSC, aged care providers, and the community was also noted to be a source of influence on IPC knowledge and practices of aged care staff and visitors. For example, requirements to wear masks, social distancing and/or venue capacity limits in public settings. The need for proactive communication is exemplified here, given that that lifting of IPC measures in the community may not always align with requirements in aged care homes, and may vary between homes.

A whole of organisation approach to IPC through the improvement of IPC training requirements for all aged care home staff was suggested, as IPC is everyone's responsibility.

Stronger engagement with residents' families, carers, and friends on the importance of IPC protocols and how they apply to the aged care home and individual residents was noted to be important to the engagement and compliance with IPC practices.

- FINDING 10** The IPC Lead role needs to be more proactive now and focus on IPC issues and practices more broadly to respond to future threats.
- FINDING 11** A whole of organisation approach to IPC including stronger engagement with residents' families, carers and friends is required.

4.4.2 Modification of the IPC Lead role in other aged care settings

Stakeholders, aged care homes and IPC Leads agree that some form of IPC expertise and training is needed in all aged care settings.

The development of an education framework with a role-based approach to undertake IPC training specific to community-based aged care service settings was suggested by stakeholders. Alignment to the service type and setting to ensure a holistic approach was noted favourably by stakeholders and aged care homes, using a risk-based approach relevant to the consumer profile.

An IPC focused role at an organisational level to provide guidance and support to aged care staff was suggested to be appropriate for community-based aged care service settings (including home care). Some aged care

4 KEA 1: IMPLEMENTATION

homes suggested IPC measures were less likely to have the same impact in less controlled environments such as home care.

The reported uncertainty in alignment of IPC practices in other aged care settings was also reflected in the current IPC Lead survey response to the question if the IPC Lead role could be modified to support other aged care providers. Over half (52%) were unsure, 41% agreed and 7% said no. Limited feedback from respondents largely suggested a risk-based approach and IPC principles relevant to the aged care home setting and simplified/targeted IPC training requirements. An IPC component was also suggested to be a standard component in all health and aged care processes/settings, and alternatively IPC consultancy services may be used.

The application of IPC practices in other aged care settings presents an opportunity to explore and understand further given the differences between environments.

FINDING 12 A risk-based approach to IPC capability and practice is appropriate to aged care services in community-based settings, however this represented an area of uncertainty and was suggested to need further consideration.

4.4.3 Lessons learnt from the implementation of the IPC Lead

Workforce

The selection of an aged care nurse able to fulfil and commit to the required training and activities of the IPC Lead role was highlighted to be essential.

Stakeholders, aged care homes and IPC Leads reported the IPC Lead role was implemented in haste (in response to COVID-19) and proved challenging to section time for staff to complete the required IPC training. Anecdotal evidence suggests that nominated aged care staff completed the study in

their own time. A minimum of 80 hours is the estimated time required to complete the ACIPC Foundational IPC course. Aged care nurses nominated to complete the IPC training were not always the most appropriate nurses to undertake the training and/or it was difficult to find an appropriate nursing staff member. The aged care nurse workforce profile was noted by stakeholders to typically comprise less experienced nursing staff, staff for whom English is a second language, and/or staff who may have completed a Vocational Education and Training level qualification. As a result, not all IPC course participants were prepared for or fully engaged to complete the postgraduate level training course.

Attracting and retaining IPC Lead roles were also impacted by existing workforce challenges (particularly those experienced in rural and remote locations), as discussed in more detail in section 7.3.

Scope and purpose of IPC Lead role

The IPC Lead role was implemented in December 2020 in response to the Royal Commission into Aged Care Quality and Safety's Aged care and COVID-19: a special report recommendation that all aged care homes should have a dedicated role trained in IPC. Stakeholders were of the opinion IPC may not be viewed as a priority now the COVID-19 pandemic is over. However, the need for continued IPC expertise to address IPC issues more broadly and respond to future threats was thought to be essential by stakeholders and aged care homes.

Stakeholders relayed anecdotal experiences and perceptions that IPC is the sole responsibility of the IPC Lead in an aged care home. The delegation of sole responsibility and accountability for IPC in addition to the IPC Lead role's other functions was reportedly a source of stress for some, potentially a contributing factor to IPC Lead turnover.

Case studies revealed variation in implementation of the IPC Lead role. This may be a reflection of the reported lack of clarity around the scope and expectations of the IPC Lead role by aged care homes and IPC Leads. Most respondents (82.8%) to the IPC Capability Survey reported the IPC Lead role

4 KEA 1: IMPLEMENTATION

to be defined within their position description. However, the variation in implementation of the IPC Lead role suggests there may also be variation in these position descriptions.

Training and support

Stakeholders, aged care homes and IPC Leads reported that variation in IPC information, guidance and practices created confusion for the IPC Lead role and the aged care sector in general. IPC practices specific to the aged care home setting were limited and open to interpretation (to apply and adapt to individual aged care home /settings). Each jurisdiction was also required to follow their state and territory government health authority advice. Consistency in approach, with a single source of truth, along with specialist advice and peer-to-peer support were felt to be essential.

Stakeholders and aged care homes highlighted the soft skills needed to undertake the IPC Lead activities in addition to the required IPC training. The implementation of IPC policies, protocols and practices requires change management and communication skills to influence. Several respondents to the current IPC Lead survey also cited the negative impact of the role on relationships with other aged care staff as a result of trying to influence change in IPC practices. Monitoring, and reporting skills are furthermore essential elements of the IPC Lead role.

Respondents to the 'former IPC Lead' survey reported one of the main reasons (~36%) for leaving the IPC Lead role to be a lack of support to undertake the role including lack of recognition and/or remuneration. Several respondents described the responsibilities of the IPC Lead role as being in addition to their primary role, and/or had to complete the IPC training in their own time. Several respondents also described the IPC training as being difficult to complete or did not adequately prepare them for the IPC Lead role.

Aged care homes described the need for ongoing financial support for the IPC Lead role, and access to local external IPC expertise when needed.

FINDING 13 Consolidated information, resources, and access to expertise (including peer support) were suggested improvements along with recognition of the role (remuneration, dedicated time).

5 KEA 2: APPROPRIATENESS

This chapter focuses on KEA 2: Appropriateness of the IPC Lead program; it explores the **perception and experience of the IPC Lead role by the aged care sector stakeholders**.

KEY INSIGHTS

Summary:

- There is a lack of formal peer-to-peer and/or expert support widely available for IPC Leads to access.
- There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively.
- There was a reported uplift in IPC capability across all aged care home staff, including improved IPC governance and education/training.
- Residents' family members'/carers' perception of the residents' experience and quality of life is lower than residents, acknowledging this may have been influenced by a range of factors, which may include the impact of IPC practices.
- There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices.
- There is a felt lack of support for the IPC Lead role. A range of mechanisms exist to access external IPC supports, dependent on local relationships and arrangements.
- The downstream impact of IPC practices on aged care home residents, their families, friends, and carers were reported by stakeholders to be

largely felt in residents with dementia, other cognitive impairment issues, and end of life.

KEA 2 QUESTIONS

The key evaluation questions to be addressed under KEA 2: Appropriateness are as follows:

1. How satisfied are the aged care sector and other stakeholders, including IPC Leads, with the IPC Lead role and the support it receives?
2. How do residential aged care recipients, their families and carers view the IPC Lead role?
3. Do IPC Leads feel empowered and supported to undertake their role?
4. Do peak representative bodies feel that the IPC Lead role has improved the safety of care provided to residential aged care recipients?

ANALYSIS AND FINDINGS

5.1 SATISFACTION WITH THE IPC LEAD ROLE

Stakeholders noted the lack of formal peer-to-peer or expert support for IPC Leads. Large aged care organisations were more likely to facilitate an internal working group for IPC Leads to share learnings and practices and develop IPC focused quality system elements. For example, IPC audit schedules and

5 KEA 2: APPROPRIATENESS

tools, online learning platforms, regular quality and safety group meetings (multi-site).

The variation in the level of support by aged care providers to enable IPC Leads to undertake the role (e.g. dedicated time to undertake IPC activities, ongoing training) was highlighted by stakeholders. Professional development was reported to be driven at the provider and individual levels.

The perceived lack of support and subsequent satisfaction in the IPC Lead role is also reflected in the overall satisfaction with the IPC Lead role. IPC Lead surveys reported this to be 60% and 69% of former and current IPC Leads respectively to be satisfied or very satisfied.

Various IPC resources such as webinars and guides were reported by some stakeholders to be available online to access freely. The absence of IPC refresher training was noted consistently by stakeholders and case study sites.

Aged care homes reported a general uplift in IPC capability across all aged care home staff. Changes in IPC practices over the last couple of years focused on improved handwashing/sanitising, mask wearing and COVID-19 testing (RATs) along with a rapid approach to all infectious disease [outbreak management] now. Most (82.5%) respondents to the current IPC Lead survey also felt that aged care home staff capability to respond to infectious disease outbreaks was somewhat or much better, as was the transmission of infectious disease in aged care homes (81.1%). Several aged care homes also cited a more risk-based approach to IPC now as well as improved governance of IPC issues and regular education.

Our outbreaks don't look like they did 2 years ago – got a plan, systems, everyone knows what they are doing

This feedback suggests that the IPC Lead role has played a key contribution in the improvement in IPC capability and practices in aged care homes, however support for the role needs to be strengthened.

FINDING 14 There is a lack of formal peer-to-peer or expert support widely available for IPC Leads to uniformly access.

FINDING 15 There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively.

FINDING 16 There was a reported uplift in IPC capability across all aged care home staff, including improved IPC governance and education/training. However there is continual learning and development required.

5.2 CONSUMER PERCEPTION OF THE IPC LEAD ROLE

5.2.1 Consumer Experience and Quality of Life indicators

Aged care providers are required to collect and report on Consumer Experience and Quality of Life from 1 April 2023 as part of the National Aged Care Mandatory Quality Indicator Program.

Please note: HMA reviewed the data on Consumer Experience and Quality of Life and originally included it in this report; however, it needed to be redacted due to its non-public release.

The Quality of Care Experience Aged Care Consumers © Flinders University 2022 (QCE-ACC) (1) tool is used to measure consumer experience. The Quality of Life Aged Care Consumers © Flinders University 2022 (QOL-ACC) (2) tool is used to measure quality of life. These tools contain questions focused on social relationships and connections, wellbeing, and appropriateness of staff delivering care. While the questions don't specifically ask about IPC practices, these aspects could be impacted by IPC practices in

5 KEA 2: APPROPRIATENESS

aged care homes and an outcome of the IPC Lead role activities (implementing IPC practices, outbreak management, and staff education).

FINDING 17 Residents' family members'/carers' perception of the residents' experience and quality of life is lower than that of residents themselves. This may be influenced by a range of factors, including the impact of IPC practices.

5.2.2 Consumer awareness

Aged care homes felt aged care residents and family/carers/friends were more aware of and/or likely to practice handwashing, mask wearing and COVID-19 screening when required now. This was reflected in the range of IPC practices family/carers/friends of residents reported to be in place including:

- Mask wearing by visitors and staff
- Hand sanitiser and sinks readily accessible throughout aged care home
- Additional bins with lids available throughout aged care home
- RAT and temperature testing on entry
- IPC signage and information throughout the aged care home
- Equipment is cleaned after every use.

Communication of IPC issues and aged care home processes was felt by aged care homes to be more proactive and organised. The impact of initial lockdowns and restrictions was acknowledged to impact social connections, however improved IPC knowledge has resulted in reduced social isolation and better communication with family/friends/carers.

Definitely less complaints when outbreaks occur now there is some structure (processes, communication, direction, and assurance)

Family/carers/friends reported aged care homes were now more organised and proactive in terms of communication of IPC practices and outbreaks (emails, newsletters, phone calls, text messages). Aged care homes were also reportedly quick to respond to outbreaks, with better isolation practices, less restrictive visitation, and a bigger focus on social connection and wellness. Video calls and more social events/spaces in the aged care home were cited examples of improved wellbeing aspects.

IPC-related complaints made to the ACQSC in 2019–20 to 2022–23 by consumers (residents, aged care staff, family/carers/friends of residents, other) were reviewed (see Appendix B). The number of IPC-related issues identified in complaints totalled 1,741, 2,004 and 1,742 across 2019–20 to 2021–22 respectively before decreasing to 696 in 2022–23. Issues related to IPC preparedness & prevention, visitor restrictions, and IPC-related to healthcare and personal care represented the most concerns. This trend reflects the reported increase in improvement in IPC practices (less restrictive visiting) and communication with residents and their family/carers/friends now. The overall number of individual complaints were also elevated across 2019–20 to 2021–22 (1,380 to 1,498) and decreased to 611 in 2022–23.

Aged care homes also reported cultural beliefs in some communities had resulted in challenges with recognition of COVID-19, vaccinations, and IPC practices. The level of awareness around the need for IPC practices to continue now, post-Covid-19 pandemic, was also thought to be low, likely attributable to reduced messaging and IPC measures in the community.

Family/carers/friends were aware of an IPC focused role in the aged care home and largely assumed this to be placed with a leadership role (e.g. nurse unit manager, director of nursing). Overall family/carer/friend sentiment towards IPC practices was that it is reassuring to have expertise to draw on and lead the home, however the overall wellbeing of residents was paramount. Personalised care was key along with a whole of aged care home approach, i.e. all staff should be involved in IPC practices.

5 KEA 2: APPROPRIATENESS

FINDING 18 There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices.

5.3 FELT SUPPORT FOR IPC LEADS

As discussed earlier in section 4.4 one of the main reasons for leaving the IPC Lead role related to a felt lack of internal organisation support to undertake the role including lack of recognition and/or remuneration.

Similarly, only 62% of respondents to the current IPC Lead survey were satisfied (50%) or very satisfied (12%) with the overall support to undertake the role. With differing levels of aged care home/provider support for IPC Leads available, this highlights the need for IPC Lead access to external IPC supports. Aged care homes and IPC Leads reported a range of mechanisms to access IPC expertise (public health units, Local Health Districts, ACIPC, health authorities). This suggests external support is dependent on local relationships and arrangements.

The lack of access to formalised peer support aligns with stakeholder sentiment expressed earlier in section 5.1. Noting however there is a moderated and curated online aged care IPC forum planned to be launched by ACIPC.

FINDING 19 There is a perceived lack of organisational support [aged care home provider] for the IPC Lead role to varying degrees stemming from tangible support to acknowledgement of the role.

FINDING 20 A range of mechanisms exist to access external IPC supports; these are typically dependent on local relationships and arrangements.

5.4 IMPROVEMENT IN DELIVERY OF SAFE CARE

The downstream impact of IPC practices on aged care home residents, their families, friends, and carers were reported by stakeholders to be largely felt in residents with dementia, other cognitive impairment issues, and end of life. Reduced access to social supports and connections for these cohorts was perceived to be potentially detrimental. There was a felt need to further understand the impact of IPC practices on aged care home residents with dementia or other cognitive impairment/behavioural conditions. Learnings from the community mental health services experiences with consumers during COVID-19 were also suggested to be explored.

IPC measures were reportedly seen to be a potential barrier to everyday activities and/or social connections essential to aged care residents with dementia, other cognitive impairments, or end of life from the perspective of some families, carers, and friends. An individual approach to residents was required.

The IPC Lead role function was suggested to also ensure the social connections of aged care home residents are preserved (per the aged care visiting code).

There was thought to be an increased awareness of IPC practices (e.g. hand washing) in residents' families, carers, and friends since the COVID-19 pandemic. Hand washing and mask wearing were noted to be common practice. However, the IPC messaging from aged care providers, and in the community was highlighted to be a likely contributing factor. This suggests continued messaging and engagement with residents and their family/carers/friends is needed.

Respondents to the IPC Lead survey felt resident and visitor safety was now somewhat or much better (80%). The main perceived impact to residents was increased quality of care and safety. While increased awareness of the importance of IPC by residents was suggested, lockdowns/restrictions and isolation practices were thought to negatively impact on residents' mental

5 KEA 2: APPROPRIATENESS

wellbeing. The use of PPE (i.e. masks) by staff was also highlighted by several to make it difficult for residents to hear and understand staff, particular those with dementia. The main felt impact to visitors (families, friends, carers of residents) was increased awareness of the importance of IPC (visiting restrictions, IPC screening practices). However, several respondents felt there was no impact, and there were still pockets of IPC resistance and/or frustration with IPC practices by visitors.

The perception and understanding of IPC practices and the need for by visitors to aged care homes is likely also influenced by the messaging and practices in the community. Given the messaging in the community is predominantly centred on COVID-19, awareness on the need for IPC to prevent transmission of all infectious disease may still be low.

FINDING 21 The downstream impact of IPC practices on aged care home residents, their families, friends, and carers were reported by stakeholders to be largely felt in residents with dementia, other cognitive impairment issues, and end of life.

FINDING 22 Social connections and overall wellbeing are critical to counterbalance and maintain in applying IPC practices.

6 KEA 3: SUPPORT

This Chapter focuses on KEA 3: Support, it explores **how well the IPC Lead role has been supported**.

KEY INSIGHTS

Summary:

- Funding for continued professional development and support for both the IPC Lead and aged care home staff was suggested.
- The provision of IPC guidance, knowledge, support and practices should be delivered in a risk-based approach appropriate to the care setting and consumer profile.
- Time to undertake regular ongoing training and professional development was widely suggested, however access to undertake this was insinuated to be a part of the IPC Lead role activities.
- The need for organisational leadership and management to support and drive improvement and change in IPC practices and lead the management of outbreaks was highlighted.
- Access to IPC expertise and peer support was sought through a community of practice and better integration with the health sector.
- Targeted training to supplement the core IPC training was suggested with a focus on aged care resident cohorts (e.g. dementia, palliative care) and practical applications to the aged care setting.
- Aged care homes in rural and remote settings faced similar challenges in the implementation of the IPC Lead role, with key implementation drivers relating to IPC advice coverage and workforce protection.

KEA 3 QUESTIONS

1. Are residential aged care services investing appropriately in the IPC Lead role?
2. Do IPC Leads have access to the necessary training? And are they able to make the time to engage in it?
3. Are there opportunities to improve the support provided to the IPC Lead role?
4. How has the remoteness classification of aged care homes affected their ability to implement the IPC Lead role?

ANALYSIS AND FINDINGS

6.1 INVESTMENT IN THE IPC LEAD ROLE

As discussed in section 4.2, nearly 40% (969) of aged care homes submitted at least one application for the IPC Training Grant round ending June 2023. Stakeholders consistently reported the need for funding to continue professional development and support for both the IPC Lead and aged care home staff. Refresher training to reflect the current environment and appropriate approach moving forward was suggested along with formalised peer-to-peer support platforms and access to IPC expertise.

6 KEA 3: SUPPORT

IPC practices need to be considered in a risk-based approach, relevant to the identified need, including resident profile, of the care setting, with training to reflect this accordingly (e.g. IPC and dementia, IPC, and palliative care).

There was a reported need for guidance on the level of IPC Lead support required relevant to the size and resident profile of the aged care home. Similarly, the need for more than one trained IPC Lead or champions (staff who volunteer or are selected to support and promote IPC practices in their organisation to support the IPC Lead) was suggested. For example aged care staff were reported to be delegated to regularly check PPE stock levels and expiry dates, and aged care nurse were allocated responsibility to demonstrate hand hygiene practice to aged care workers. Administration staff were also tasked with assisting visitors with any screening and IPC practices (e.g. mask wearing, hand sanitising) in some instances.

FINDING 23 The provision of IPC guidance, support and practices should be delivered in a risk-based approach appropriate to the care setting and consumer profile.

6.2 ACCESSIBLE IPC TRAINING

While 75% of respondents to the current IPC Lead survey were satisfied or very satisfied with access to information and training, satisfaction with dedicated time to undertake professional development and access peer support platforms ranged from 48% to 55%.

The types of accessible training and support for IPC Lead roles reported by aged care homes varied between jurisdictions and provider types (discussed in further detail KEA four section 7.4). Regular ongoing training and professional development was widely suggested, however access to undertake this was insinuated to be a part of the IPC Lead role activities.

FINDING 24 Time to undertake regular ongoing training and professional development was widely suggested, however access to

undertake this was assumed to be a part of the IPC Lead role activities.

6.3 OPPORTUNITIES TO IMPROVE SUPPORT

Stakeholders consistently highlighted the need for organisational leadership and management to support and drive improvement and change in IPC practices and lead the management of outbreaks.

6.3.1 Access to IPC expertise and peer support

Stakeholders consistently reported the need for a community of practice for IPC Leads to access and participate in, with IPC expertise to provide guidance and support to aged care homes. As discussed in sub-section 2.1, larger aged care organisations were more likely to facilitate an internal working group for IPC Leads to share learnings and practices. Larger aged care providers reported the use of internal IPC expertise to provide guidance and support to IPC Leads and aged care homes. Respondents to the current IPC Lead survey also noted organisational IPC support and training to be valuable and suggested that the IPC Lead role needed to be integrated into organisational governance structures (e.g. clinical governance). This would enable visibility of the IPC Lead activities and outcomes, particularly within the broader remit of the organisation's compliance with the Aged Care Quality Standards and quality of care.

Further integration with the health sector was suggested to be a logical step to leverage existing expertise and facilitate consistent IPC principles and core practices. Primary Health Networks (PHNs) were also suggested as a source of support along with Public Health Units (PHUs). This is particularly noteworthy given the role of a PHU to provide public health advice in response to notifiable conditions and/or outbreaks and their funding as such to perform this function. The provision of expert IPC advice and support

6 KEA 3: SUPPORT

specific to the aged care home sector from PHUs is possible, however, with the consideration of any requisite additional resources and funding.

Similarly, respondents to the current IPC Lead survey suggested access to communities of practice and public health authority/IPC expertise for training and information to improve IPC Lead support.

FINDING 25 Access to IPC expertise and peer support was sought through communities of practice and better integration with the health sector.

6.3.2 Training

Targeted training modules and tools to supplement the required IPC training for IPC Leads were felt to be needed by stakeholders and aged care homes to enhance the practical application of IPC principles to the aged care home setting.

This was also reflected in the current IPC Lead survey respondent feedback to improve training. Additional IPC training and information/tools specific to aged care were suggested. Dedicated time to access and undertake IPC training and participate in peer support activities was strongly suggested in conjunction with dedicated FTE to adequately undertake IPC Lead role activities. Education materials for all aged care staff, visitors, families/friends/carers (including other languages) were also suggested to increase the effectiveness of IPC practices.

Several respondents also suggested additional funding for IPC Leads to undertake the role and access and participate in ongoing professional development along with additional information to understand the responsibilities of the IPC Lead (e.g. inclusion in job description).

The lack of dedicated FTE for the IPC Lead role suggests a broader lack of clarity and expectations of the role in sector leaders. This may in part be due

to the absence of guidance on the use of the IPC Lead role as an individual and as part of organisation quality and safety systems.

As highlighted earlier in section 4.4 soft skills – change management and communication skills – are needed to influence change in an organisation. These types of skills along with monitoring, insight and reporting skills are essential elements of the IPC Lead role.

Several survey respondents and aged care homes also suggested better integration of the IPC into clinical quality and safety governance structures.

FINDING 26 Targeted training to supplement the core IPC training was suggested with a focus on aged care resident cohorts (e.g. dementia, palliative care) and a practical application to the aged care setting.

6.4 IMPACT OF REMOTENESS CLASSIFICATION ON IMPLEMENTATION

The implementation costs for an IPC Lead do not vary between aged care home remoteness settings as the IPC training can be completed online and the IPC Training Grant course fees are capped with up to 80 hours study leave and backfill. As mentioned in section 4.2, aged care homes reported the need for IPC expertise to be available at all times (i.e. more than one IPC Lead was needed) as outbreaks can occur at any time. For aged care homes in remote settings, access to aged care staff is more challenging, highlighting the importance of IPC coverage to enable staff leave and minimise staff illness/sick leave. A regional approach to IPC support was reported for WA MPS sites with an IPC nurse available to provide support to IPC Leads and MPS sites during transition between IPC Leads or leave of absences.

FINDING 27 Aged care homes in rural and remote settings faced similar challenges in the implementation of the IPC Lead role, with key

6 KEA 3: SUPPORT

implementation drivers relating to IPC advice coverage and workforce protection.

7 KEA 4: IMPACT

This Chapter focuses on KEA 4: Impact, it explores **how the IPC Lead role has impacted the role of nurses.**

KEY INSIGHTS

Summary:

- The IPC Lead role was noted to have provided a valuable opportunity for aged care nurses to upskill and enable career progression to higher roles (within aged care and other sectors) in some instances.
- Not enough time was dedicated to the IPC Lead role and reportedly impacted aged care nurses' other duties to varying degrees.
- Workforce challenges in the attraction and retention of appropriate and engaged aged care nursing staff continue to impact providers consistently meeting IPC Lead requirements.
- Additional expertise (internal or external) and relevant resources are needed to support the IPC Lead role and aged care homes more broadly.
- The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most former IPC Lead roles reportedly remaining in the aged care sector once leaving the IPC Lead role.
- The turnover in the IPC Lead role can translate to a loss in corporate knowledge of IPC unless the aged care home staff have a baseline knowledge of IPC that is integrated into quality and risk systems.

KEA 4 QUESTIONS

1. What impacts has the introduction of the IPC Lead role had on the nursing sector?
2. How has the IPC Lead role impacted the other aspects of a nurse's role in aged care homes?
3. What barriers and challenges exist in terms of providers meeting IPC Lead requirements?
4. To what extent does the training requirement prepare IPC Leads to fulfil the role?
5. How has aged care home staff turnover impacted the IPC Lead program delivery in aged care homes (if at all)?

ANALYSIS AND FINDINGS

7.1 IMPACT ON NURSING SECTOR

The IPC Lead role was noted to have provided a valuable opportunity for aged care nurses to upskill and gain confidence and knowledge in IPC practices. The IPC qualification enabled career progression to higher roles (aged care management, coordination roles) in some instances for IPC Leads.

This sentiment was also reflected in discussions with aged care homes and respondents' feedback in the current IPC Lead survey to the impact of the IPC Lead role on nursing career pathways in aged care. The expanded scope

7 KEA 4: IMPACT

of the aged care nurse along with the attractive qualification increasing career opportunities was commonly reported. Survey respondents felt the IPC Lead role was an opportunity to reduce harm to aged care staff and residents, while highlighting the importance of an organisational approach to IPC. Conversely, there was opinion the IPC Lead role was an increase in workload pressure, a responsibility of all nursing staff, and no impact to aged care nursing career pathways was reported.

Key drivers to undertake the IPC Lead role were also reported to include career pathway opportunity and upskilling. Nearly half (47%) of respondents viewed the IPC Lead role (and training) as a professional development opportunity, and career pathway opportunity (33%). However over half (53%) of the respondents to the current IPC Lead survey reported they were asked by their employer to undertake the IPC Lead role. Over half (58%) of respondents also agreed or strongly agreed the IPC Lead role has improved nursing career pathways and opportunities in aged care homes.

FINDING 28 The IPC Lead role was noted to have provided a valuable opportunity for aged care nurses to upskill and enable career progression and opportunities.

7.2 IMPACT ON NURSING ROLE

Despite the perceived career opportunity, 40% of respondents to the current IPC Lead survey reported that the IPC Lead role impacted other aspects of their aged care nurse role mostly or always. This reflects the lack of reported dedicated FTE for the IPC Lead role. Key feedback indicated the IPC Lead role to be an add-on to their existing nursing role and impacted either or both. Not enough time was dedicated to the IPC Lead role. Several respondents reported the greatest impact to be during an active outbreak.

FINDING 29 Not enough time was allocated specifically to the IPC Lead role which impacted aged care nurses' other duties to varying degrees.

7.3 BARRIERS AND CHALLENGES TO MEET IPC LEAD REQUIREMENTS

Stakeholders and aged care homes consistently relayed the workforce challenges in the learnings from the implementation of the IPC Lead role. Aged care providers found attracting and retaining aged care nursing staff difficult, particularly in rural and remote locations. Salary agreements and work environment conditions were noted to affect the attraction and retention of nurses in aged care, and subsequently the IPC Lead role.

As discussed earlier in section 4.4, there were also difficulties in identifying an appropriate and engaged aged care nurse to undertake the IPC Lead training and role.

IPC Leads consistently highlighted the importance of allocation of time to undertake the IPC training and IPC Lead role activities.

Hard doing your main job plus the course

While attracting and retaining IPC Lead roles was noted to be impacted by workforce challenges, 65% of former IPC Leads reportedly remained in the aged care home setting. This means aged care homes may be attracting new nursing staff that may already have IPC training. Other aged care settings represented 5%, while transition to the health setting represented 10% and 20% to government, other organisations, or other reasons. Half of former IPC Lead roles remained in nursing with a third transitioning to management roles. Funding, training, education, and retirement were also reported transition outcomes.

7 KEA 4: IMPACT

The initial variation and frequent change in IPC information (guidance and practices) during the implementation of the IPC Lead role was cited to be a contributing challenge by IPC Leads and aged care homes.

FINDING 30 Workforce challenges in the attraction and retention of appropriate and engaged aged care nursing staff continue to impact providers consistently meeting IPC Lead requirements.

7.4 APPROPRIATENESS OF IPC TRAINING

Stakeholders and aged care homes were of the opinion the approved IPC training was focused on the general principles of IPC. A practical component was thought to be lacking from the current ACIPC IPC training (Foundational course) and aged care specific resources (publicly accessible/visible) are still limited. There was suggested value in the selection and use of auditing and surveillance tools for IPC Leads. Aged care homes highlighted the acute care setting was markedly different from the aged care home setting. It is noted that the ACIPC Foundation course has been recently revised to include more contextual information specific to aged care. The application of the IPC principles and practices to the aged care setting was a felt gap in better preparing IPC Leads.

Need to make it simpler and have more critical thinking – more focused on the practical application

Over 80% of current IPC Lead survey respondents completed the ACIPC Foundations of IPC course, with 85% also completing the aged Care COVID-19 Infection Control online training modules. 73% of respondents agreed or strongly agreed the approved IPC training was of relevance to the aged care setting.

Aged care homes reported instances of internal organisation or external IPC consultancy support to reinforce IPC learnings relevant to the aged care home. Integration of the IPC Lead role with organisation clinical quality and

safety governance and use of aged care home staff to undertake specific IPC tasks were reported examples of organisational supports. Access to support through ACIPC was also cited along with limited regional public health unit/Local Health District IPC sessions. While there were examples of interactions with PHUs, most aged care homes described these interactions to be restricted to outbreaks of infectious diseases.

Centre for communicable disease through jurisdictional health authority – we can call any time which is great – [for example we] recently had a case of an obscure strep infection

This feedback suggests that while the relevance of IPC training is important, continued access to information and supports for IPC Leads to adequately undertake the role is required.

As discussed in key evaluation area three (sections 6.1 and 6.3) there was a perceived opportunity for improvement to further target and/or supplement the current IPC training requirement to reflect the aged care home resident profile (e.g. dementia, palliative care).

FINDING 31 Additional expertise (internal or external) and relevant resources are needed to support the IPC Lead role and aged care homes.

7.5 IMPACT OF STAFF TURNOVER

Sections 4.2, 4.4 and 6.3 highlighted the workforce challenges that continue to impact the IPC Lead role. It is important to acknowledge that workforce challenges existed prior to the IPC Lead role and that the COVID-19 pandemic was likely a large stressor adding to the issues.

Analysis of the IPC Lead program data (Quantum June 2023) indicated the IPC Lead role turnover had decreased to 22% as of May 2022. This aligns with the reported challenges in identifying suitable aged care nursing staff to

7 KEA 4: IMPACT

complete the IPC training and undertake the role in the earlier stages of implementation. Aged care homes in metropolitan and regional settings experienced a higher turnover rate (24%) compared to rural and remote aged care homes (18%). This is expected given there are likely to be more job opportunities in metropolitan and regional settings.

Several aged care homes described challenges with losing IPC trained staff to other aged care homes or the acute care setting. However, the likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care still. Several respondents to the former IPC Lead survey also reported to have completed the IPC training and had transitioned to a higher role and/or were now the backup IPC Lead.

The turnover in the IPC Lead role can translate to a loss in corporate knowledge of IPC unless the aged care home staff have a baseline knowledge of IPC that is integrated into quality and risk systems.

FINDING 32 The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care still.

FINDING 33 The turnover in the IPC Lead role can translate to a loss in corporate knowledge of IPC unless the aged care home staff have a baseline knowledge of IPC that is integrated into quality and risk systems.

8 SWOT ANALYSIS

A SWOT analysis has been completed based on the findings of the IPC Lead evaluation presented in Chapters 4 to 7.

STRENGTHS

The key strengths of the IPC Lead role program lie in the opportunity for aged care nurses to upskill and gain confidence in a specialist area, and actively contribute to the quality care delivered by aged care providers in line with the Aged Care Quality Standards.

WEAKNESSES

The absence of guidance or direction in the implementation of the IPC Lead role has resulted in variations in the level of support by providers to enable the IPC Lead. This in turn can result in pockets of professional isolation exacerbated by a lack of formalised expertise or peer support and access advice. The perception that IPC is the sole responsibility of an IPC Lead role also lends itself to being person-dependent, which goes against the whole of organisation and systems approach to effective implementation of IPC practices.

OPPORTUNITIES

There is an opportunity to integrate better with the public health sector and leverage IPC expertise to ensure consistent IPC practices for consumers transitioning between the health and aged care home sector. A community of practice could offer access to IPC expertise and peer support, at a

local/regional level and/or online. Acknowledging the principles of IPC are core to both health and aged care, there is also an opportunity to enhance IPC training and resources specific to the aged care home setting. These additional resources may serve a dual purpose for ongoing professional development to enhance the IPC Lead role, and for aged care staff more broadly. Guidance to use the role to encompass a more organisational approach to IPC that includes stronger guidance to this effect in the Aged Care Quality Standards.

THREATS

Workforce challenges continue to threaten the turnover of aged care nurses and the IPC Lead role. The cessation of the IPC Training Grant (at this point in time) will become a cost incurred by providers (training course, study leave, backfill) that may become untenable if there is continued frequent turnover in the IPC Lead role. The IPC Lead role was implemented in response to the COVID-19 pandemic and the Royal Commission in Aged Care Quality and Safety special report recommendation to boost IPC capability in aged care homes. With the reduced threat of COVID-19, there is a risk IPC is less of a concern or priority now.

POLICY INSIGHTS AND CONSIDERATIONS

Insight into the IPC capability of the aged care home sector is critical to understanding quality and education systems in place to prevent and respond to all infectious disease and outbreaks to which the IPC Lead role provides advice and guidance. The ACQSC IPC Capability Survey is an existing mechanism to monitor this.

8 SWOT ANALYSIS

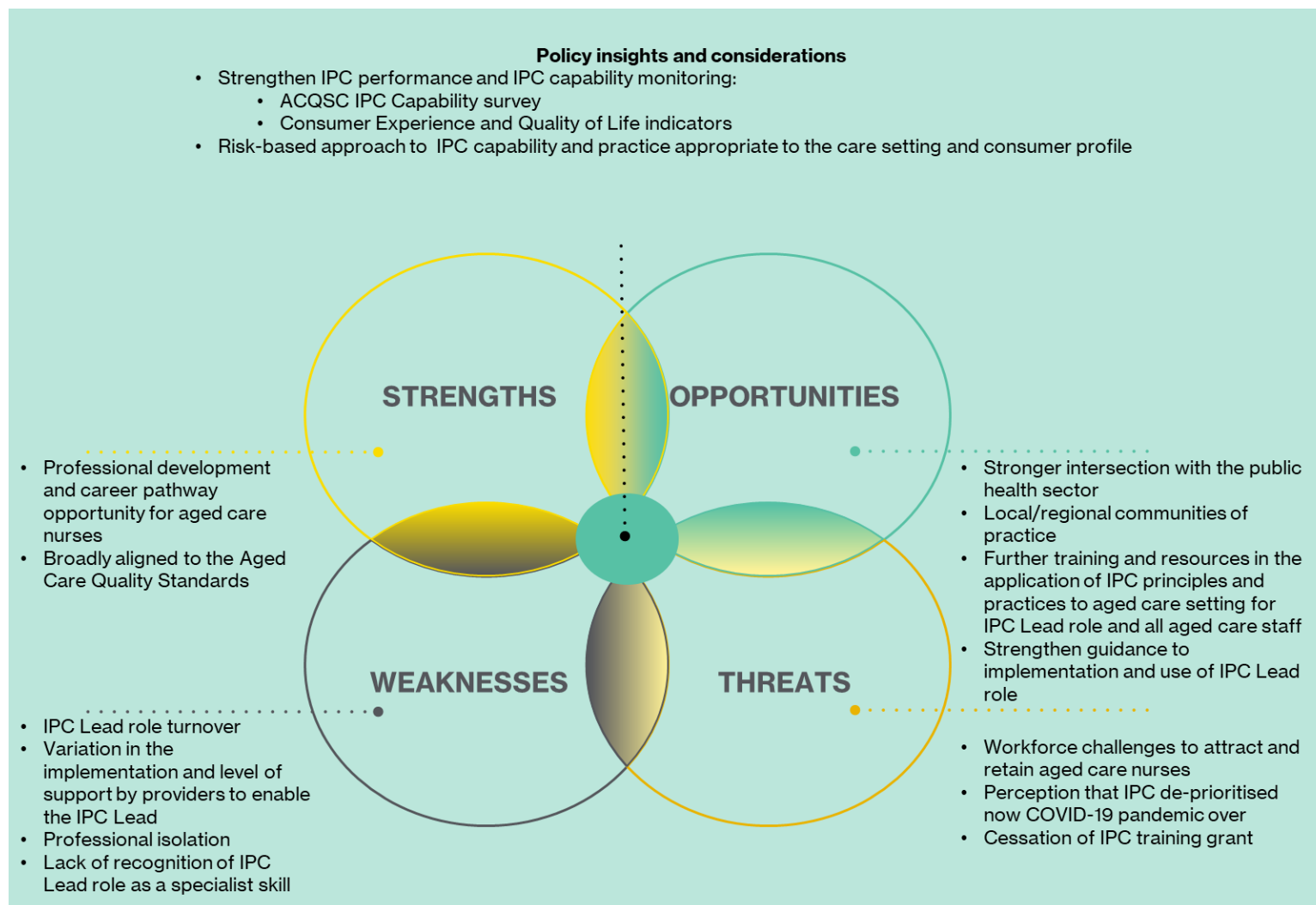
With the reduced threat of COVID-19 and variation in aged care settings and consumer profiles, it may be pertinent to consider a risk-based approach to IPC and how it is implemented to best use resources efficiently and

effectively. This approach also lends itself to better balancing the social support needs of aged care residents in particular.

Figure 8.1 presents an overview of the SWOT analysis.

8 SWOT ANALYSIS

Figure 8.1: SWOT analysis



9 KEY FINDINGS AND RECOMMENDATIONS

9.1 KEY FINDINGS, OPPORTUNITIES AND RECOMMENDATIONS

The key findings across each of the four evaluation areas that represent a gap and/or an area to improve upon have been identified and aggregated. Table 9.1 presents a summary of these key findings along with the opportunities and recommendations to address these. Note that several findings have informed more than one recommendation.

Table 9.1: Summary of recommendations, opportunities and findings

RECOMMENDATIONS	OPPORTUNITIES	FINDINGS
IPC Lead program guidance		
<p>1. An IPC Lead Framework should be developed to provide more direction to aged care home providers on the implementation and integration of the IPC Lead role to support IPC capability and practices in aged care homes. The framework should include:</p> <ul style="list-style-type: none"> Development of an escalation pathway to draw in external IPC expert advice and support when required. The existing local relationships/dynamics with public health system organisations should be leveraged and formalised where possible. Guidance on the minimum FTE requirements to undertake the IPC Lead role (appropriate to the aged care home size and type) is required to enable the role to be used effectively and ensure business continuity in terms of access to IPC advice. 	<ul style="list-style-type: none"> This is an opportunity to provide guidance and set expectations on the integration and use of the IPC Lead role to support and bolster the IPC capability of aged care homes. Expectations of the IPC Lead role, objectives, and requirements to undertake the role (i.e. minimum dedicated time appropriate to the aged care home type and size) need to be outlined to provide clarity and recognition of the value add of the IPC role. Continued engagement and communication of the importance of IPC more broadly (i.e. influenza, gastro 	<ul style="list-style-type: none"> Finding 1: A range of approaches are used in addition to the IPC Lead role to work towards compliance to the Aged Care Quality Standards including external IPC consultants and organisation IPC Leads. Finding 5: With no overarching guidance, IPC Lead roles working arrangements vary widely between facilities due to variations in aged care home size, location, resident profile, and the responsibilities allocated to the IPC Lead role. Finding 6: The appointment of two IPC Leads offered continuity of advice and guidance for aged care homes. Finding 7: Aged care homes with one or more IPC Leads reported similar challenges with undertaking the role (dedicated time, ongoing professional development, and support). Finding 15: There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively.

9 KEY FINDINGS AND RECOMMENDATIONS

RECOMMENDATIONS	OPPORTUNITIES	FINDINGS
<ul style="list-style-type: none"> – Dedicated time to undertake ongoing professional development in IPC – A stronger focus on consumer engagement. <p>2. An IPC Lead role description (integrated into existing aged care nurse description) should be developed to reflect the remit of the IPC Lead role in line with the IPC Lead Framework to promote consistency and provide role clarity.</p>	<p>etc.) with family/carers/friends moving forward.</p>	<ul style="list-style-type: none"> • Finding 19: There was a perceived lack of organisational support [aged care home provider] for the IPC Lead role. • Finding 29: Not enough time was dedicated to the IPC Lead role which has impacted aged care nurse commitment to other duties to varying degrees. • Finding 32: The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care.
<p>3. Guidance should be provided on the integration of the IPC Lead role and activity outputs such as audits and communication of new IPC information into governance structures (e.g. clinical quality and safety committee).</p>	<ul style="list-style-type: none"> • The IPC Lead provides an IPC advisory service and direction to individuals and the organisation; it is not solely responsible for IPC. Integration of the IPC Lead role and activities/outputs into clinical quality and safety governance infrastructure is required to ensure visibility of IPC updates, issues, and audit outcomes. 	<ul style="list-style-type: none"> • Finding 8: The IPC Lead is not solely responsible for directing management of an outbreak. Escalation protocols are enacted, and broader clinical governance teams collectively discuss and direct the actions required. Most aged care homes feel they now have adequate systems in place to respond quickly to an outbreak. • Finding 9: Vaccination (influenza, COVID-19), good clinical governance and overall workforce capability are also contributing factors to effective IPC. • Finding 33: The turnover in the IPC Lead role can translate to a loss in corporate knowledge of IPC unless the aged care home staff have a baseline knowledge of IPC that is integrated into quality and risk systems.
<p>4. Objectives of the IPC Lead role should be re-framed and communicated to be about bolstering IPC capability and practices to manage all IPC issues and infectious diseases.</p>	<ul style="list-style-type: none"> • While the IPC Lead role stemmed from the COVID-19 pandemic, IPC knowledge and practices should be applied to all IPC issues and infectious diseases to sustain high-quality delivery of care. Infectious diseases continue to be a risk in aged care homes and robust IPC practices are critical to quality care. 	<ul style="list-style-type: none"> • Finding 10: The IPC Lead role needs to be more proactive now and focus on IPC issues and practices more broadly. • Finding 23: The provision of IPC guidance, support and practices should be delivered in a risk-based approach appropriate to the care setting and consumer profile.

9 KEY FINDINGS AND RECOMMENDATIONS

RECOMMENDATIONS	OPPORTUNITIES	FINDINGS
IPC Lead support		
<p>5. Consider an annual IPC Lead forum and/or regional community of practices to complement support platforms such as the ACIPC online aged care IPC forum planned. Align with sector bodies, agencies, and organisations such as ACQSC, ACSQHC, and VICNISS.</p>	<ul style="list-style-type: none"> Acknowledging the differences in provider types, maturity, and relationships with other public health organisations between jurisdictions, an escalation pathway to draw in external IPC expert advice and support when required is needed. Cross-sector support in IPC (health) mobilised in a regional approach has been used in other countries to provide IPC support and strategies to aged care. 	<ul style="list-style-type: none"> Finding 13: Consolidated information, resources, and access to expertise (including peer support) are suggested improvements along with recognition of the role through specified remuneration and dedicated time to conduct. Finding 14: There is a lack of formal peer-to-peer and/or expert support widely available for IPC Leads to access. Finding 20: A range of mechanisms exist to access external IPC supports, these are typically dependent on broader existing local relationships and arrangements. Finding 25: Access to IPC expertise and peer support was sought through communities of practice and better integration with the health sector and its support pathways. Finding 31: Additional expertise (internal or external) and relevant resources are needed to support the IPC Lead role and aged care homes more broadly.
<p>6. Consider the development of targeted IPC modules (for the aged care home setting) for ongoing professional development purposes with a suggested focus on:</p> <ul style="list-style-type: none"> End of life care Dementia and other cognitive impairment conditions Cultural awareness and considerations. 	<ul style="list-style-type: none"> Development of targeted IPC modules to supplement the approved IPC Lead training and/or for additional resources for all aged care staff to better reflect the aged care home resident profile. 	<ul style="list-style-type: none"> Finding 18: There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices (which may be associated with cultural beliefs in some settings). Finding 21: The downstream impact of IPC practices on aged care home residents, their families, friends, and carers were reported by stakeholders to be largely felt in residents with dementia, other cognitive impairment issues, and end of life. Finding 22: Social connections and overall wellbeing are critical to maintain in applying IPC practices. Finding 26: Targeted training to supplement the core IPC training was suggested with a focus on aged care resident cohorts (e.g. dementia, palliative care) and a practical application to the aged care operational setting.

9 KEY FINDINGS AND RECOMMENDATIONS

RECOMMENDATIONS	OPPORTUNITIES	FINDINGS
7. Consider identifying relevant and appropriate IPC training recommended for all aged care staff to undertake as a complementary measure to bolster IPC capability collectively in aged care homes (e.g. a role-based curriculum matrix).	<ul style="list-style-type: none"> Identify relevant and appropriate IPC training for aged care staff to undertake with the aim of aligning to existing and relevant training in the health and aged care sectors, e.g. ACSQHC aged care IPC resources and training. A role based or tiered approach to education and training requirements is an effective approach to guiding organisational capability. It is used in both health and aged care sectors in Australia and overseas. 	<ul style="list-style-type: none"> Finding 11: A whole of organisation approach to IPC including stronger engagement with residents' families, carers and friends is required. Finding 16: There was a reported uplift in IPC capability through the IPC Lead role across all aged care home staff, including improved IPC governance and education/training. However there is continual learning and development required.
Program design and funding		
8. Suggest IPC Lead roles undertake CPD activities focused on IPC as part of ongoing professional development to undertake the IPC Lead role. 9. Dedicated time to undertake ongoing professional development in IPC	<ul style="list-style-type: none"> It is important to recognise and value the IPC Lead role in order to attract and retain nurses in the role. Suggesting use of CPD points focused on IPC may encourage ongoing professional development and set expectations on currency of the role (akin to registered nurses). 	<ul style="list-style-type: none"> Finding 24: Time to undertake regular ongoing training and professional development was widely suggested. Finding 28: The IPC Lead role was noted to have provided a valuable opportunity for aged care nurses to upskill and enable career progression and/or opportunities. Finding 30: Workforce challenges in the attraction and retention of appropriate and engaged aged care nursing staff continue to impact providers consistently meeting IPC Lead requirements.
10. Consider and explore if a financial incentive to implement the minimum IPC Lead role FTE is feasible as an alternative to potential additional round(s) of IPC Training Grants.	<ul style="list-style-type: none"> With the likelihood of attracting an aged care nurse having an IPC qualification now increased, different policy levers to use the role more effectively should be considered. The need for sustainable and accessible IPC advice and support suggests sufficient resourcing is required. 	<ul style="list-style-type: none"> Finding 3: The proportion of aged care homes without an IPC Lead at any one time is more likely to be due to transition between IPC Leads rather than not being able to appoint one. Finding 15: There is variation in the level of support by aged care providers to enable the IPC Lead to undertake the role effectively. Finding 19: There was a perceived lack of organisational support [aged care home provider] for the IPC Lead role to

9 KEY FINDINGS AND RECOMMENDATIONS

RECOMMENDATIONS	OPPORTUNITIES	FINDINGS
		<p>varying degrees stemming from tangible support to acknowledgement of the role.</p> <ul style="list-style-type: none"> Finding 29: Not enough time was dedicated to the IPC Lead role and impacted aged care nurses' other duties to varying degrees. Finding 32: The likelihood of attracting an aged care nurse with an IPC qualification has now increased, with most IPC Lead roles reportedly remaining in aged care still.
11. Consider undertaking a risk assessment of other aged care settings to understand the risk profile and risk-based approach to IPC required and the potential adaptation and/or expansion of the IPC Lead role in aged care settings.	<ul style="list-style-type: none"> An assessment of other aged care settings to understand the risk profile of other individual aged care settings in further detail. 	<ul style="list-style-type: none"> Finding 12: A risk-based approach to IPC capability and practice is appropriate to aged care services in community-based settings, however this represented an area of uncertainty and was suggested to need further consideration.
Program impact (insights)		
12. Expand the IPC Lead role data reporting to include the allocated FTE per IPC Lead role and AHPRA registration number to track implementation and movement of IPC capability in the aged care home sector.	<ul style="list-style-type: none"> Performance insight within and into the IPC Lead role and outcomes is low and represents an opportunity to improve upon in order to make evidence based policy decisions. 	<ul style="list-style-type: none"> No visibility of movement of IPC Leads in the sector (between aged care homes) including FTE
13. Consider using the ACSQC IPC Capability Survey as an ongoing IPC capability indicator for aged care homes and explore the opportunity for the ACSQC to distribute the survey results in a format to allow to aged care homes to benchmark.	<ul style="list-style-type: none"> Performance insight within and into the IPC Lead role and outcomes is low and represents an opportunity to improve upon. 	<ul style="list-style-type: none"> Finding 17: Residents' family members'/carers' perception of the residents' experience and quality of life is lower than residents, acknowledging this may have been influenced by a range of factors, which may include the impact of IPC practices.
14. Continue to monitor the QCE-ACC and QOL-ACC indicators to identify any changes or trends that may be attributable to IPC practices in aged care homes.		<ul style="list-style-type: none"> Finding 18: There is an increased awareness of IPC practices (e.g. hand washing) among residents' families, carers, and friends, however there are still pockets of resistance to acknowledging required IPC practices (largely stemming from cultural beliefs).

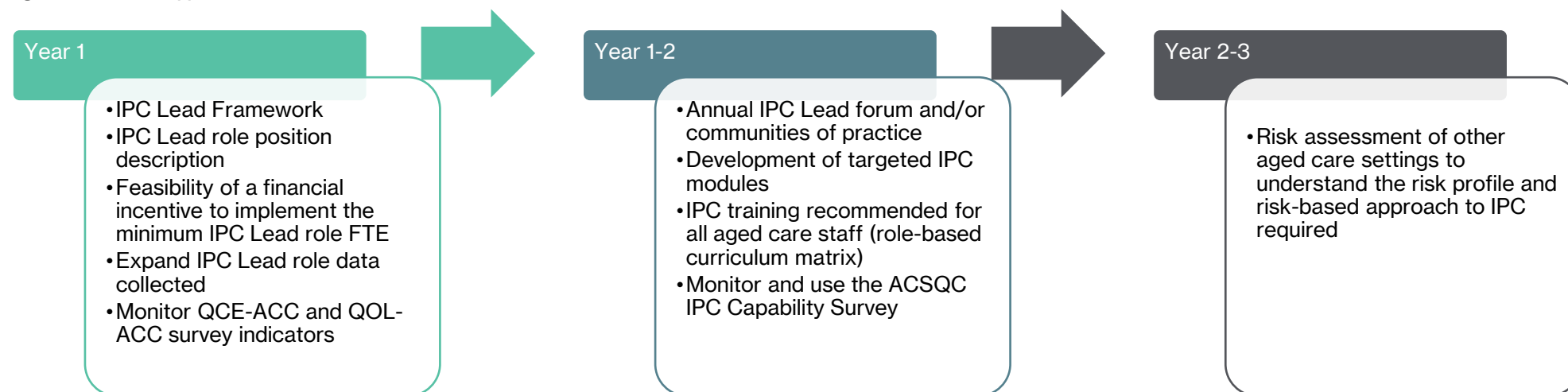
9 KEY FINDINGS AND RECOMMENDATIONS

9.2 PRIORITISATION OF RECOMMENDATIONS

Figure 9.1 presents a high-level phased approach to action the recommendations. The IPC Lead Framework and position description represent the main priorities to address in order to provide clarity and set expectations to the sector. Improvement of and continued monitoring of the IPC Lead role program delivery and impact along with exploration of potential

financial incentives are also actionable within 12 months. An IPC Lead forum presents an opportunity to gather feedback on the IPC Lead Framework and position description along with the IPC training needs of the sector. The use of the ACSQC IPC Capability Survey is suggested, followed by a review of other aged care settings in years 2–3.

Figure 9.1: Phased approach to action recommendations



10 APPENDICES

APPENDIX A AGED CARE HOME IPC POLICIES AND PRACTICES IN OTHER OECD COUNTRIES

Table 10.1: IPC practices in other OECD countries

	ENGLAND (NHS, UK)	FRANCE	DENMARK	NETHERLANDS	CANADA
IPC practices	<p>IPC is all staff responsibility working in health and social care settings, learning outcomes using the IPC education framework. There are three levels of education:</p> <ul style="list-style-type: none"> • Tier 1 Everyone working in health and social care settings • Tier 2 All staff working directly with/providing care to patients and/or who work in the patient environment • Tier 3 All staff who are responsible for an area of care <p>IPC practitioners (nurses with formal IPC qualifications)</p>	<p>Centres supporting the prevention of healthcare-associated infections (CPias) are responsible for the prevention of hospital acquired infections (HAIs) and the control of cross-transmission of infectious agents: They provide expertise and support and run networks of IPC professionals (IPC teams in hospitals and nursing homes). They also perform investigations and follow-up of reported HAIs [10].</p> <p>The IPC strategy is implemented at the local level by expert centres and mobile teams that are close to the field and have knowledge of territories and their epidemiology.</p> <p>Note CPias are distinct from Public Health France (includes regional units) which is responsible for public health</p>	<p>Individual 'abodes' with home-like living spaces in all modern nursing homes</p> <p>Highly integrated social and healthcare systems</p> <p>High COVID-19 vaccination rates for nursing home staff and residents and re-vaccination</p> <p>Paid sick leave</p> <p>Local customisation of visitor policies</p>	<p>Regional aged care home networks to share learnings and practices</p> <p>Cohorting of residents and staff</p> <p>Centralised allocation of PPE via a single new national consortium</p> <p>Outbreak teams in aged care facilities (pre-existing and specialised/adapted to COVID-19)</p> <p>Localisation of IPC practices</p> <p>Investment in communications informed by behavioural science</p> <p>Most Dutch Long-Term Care organisations have an IPC Committee</p> <p>Future adherence to IPC may be enabled by rethinking the architectural design of long-term care facilities</p>	<p>IPC Leads in long-term care homes (aged care homes)</p> <p>Facility management and workplace health and safety representatives work with IPC experts to ensure IPC practices are implemented and staff trained</p>

10 APPENDICES

	ENGLAND (NHS, UK)	FRANCE	DENMARK	NETHERLANDS	CANADA
		surveillance (similar to PHUs in Australia)			
Training	IPC education framework [11]	CPias responsible for training	Unknown	Unknown	Unknown
Guidelines and legislation (Specific to aged care setting)	<p>Care Homes: Infection, Prevention and Control (Department of Health and Social Care) [12]</p> <p>A range of general IPC and COVID-19 information and toolkits are available online (Public Health UK)</p> <p>IPC policies and resources for care homes are available online [13] (IPC NHS)</p> <p>The Health and Social Care Act 2008 [14]</p> <p>(Key lines of enquiry – S5 How well are people protected by IPC? – mapped to requirements regulated by Care Quality Commission: Regulations 12 Safer care and treatment, 15 Premises and equipment, and 17 Good governance, 18 Staff also specifically relate to IPC practices)</p>		<p>Epidemic Act</p> <p>Act on Social Services</p> <p>IPC national guidelines</p> <p>COVID-19 testing guidelines residents and staff in aged care facilities</p>	<p>Verenso, the Dutch Association of Elderly Care Physicians, develops and regularly updates directives, which are disseminated and implemented in most nursing homes through the internal crisis team</p> <p>The long-term care system is now divided between three Acts: The Long-term Care Act, the Social Support Act, and the Health Insurance Act</p> <p>National Institute of Public Health and Environment directives agreed by the Dutch government were executed in each province/region under the supervision of the Area Health Authority</p>	<p>The Public Health Agency of Canada develops evidence-informed IPC guidance to complement provincial and territorial public health efforts in monitoring, preventing, and controlling healthcare-associated infections</p> <p>Infection prevention and control for COVID-19: Interim guidance for long-term care homes [15] (Government of Canada, December 2021)</p>
Regulatory oversight	Care Quality Commission provides regulatory monitoring of care homes and conducts inspections		Danish Health Authority	Health Care Inspectorate (Ministry of Health, Welfare and Sport)	

10 APPENDICES

	ENGLAND (NHS, UK)	FRANCE	DENMARK	NETHERLANDS	CANADA
Outcome indicators	Rating characteristics for S5 key line of enquiry ⁴ [12] = outstanding, good, requires improvement, and inadequate COVID-19 positive cases and related deaths	COVID-19 positive cases and related deaths	COVID-19 positive cases and related deaths	COVID-19 positive cases and related deaths	COVID-19 positive cases and related deaths

4 UK Adult Social Care Key Lines of Enquiries and Prompts to gather evidence for safety area 5 How well are people protected by the prevention and control of infection?

10 APPENDICES

APPENDIX B ACQSC DATA

Compliance Data

Instances of non-compliance with Standards 3 (3)(g), 7 (3)(c), and 8 (3)(c) over financial years 2019/20 to 2022/23, broken down by State, Market Segment and Remoteness.

The 2022/23 Financial year includes a number of services that have an Infection Prevention Control Lead staff member.

Data Sourced via Aged Care Case Management Information System (ACCMIS) October 2023.

Notes:

Please be cautious if making comparisons between financial years.

Assessments against the Quality Standards can be undertaken through audits (scheduled activities for all services that assess all Quality Standards) or assessment contacts (which can be based on risk-based targeting and can target one or more Quality Standards for services rated as higher risk).

This mix of activities can affect the proportion of assessments with a not met finding. For example, if a greater proportion of assessment contacts are undertaken targeting a specific risk (for example, clinical care) compared to audits during a time period, then the proportion of assessments with not met findings may be higher.

In addition to the above, as a result of the COVID pandemic the Commission was unable to audit all services due for reaccreditation, therefore services were prioritised for audit based on relative risk. Assessment contacts were also targeted to specific risks, especially those linked to COVID. This may also have affected the proportion of not met against particular requirements.

Because of the above, it is difficult to compare performance of the sector across recent financial years and to attribute reasons for any change. To summarise:

- The services and providers in each time period will differ, based on risk (some financial years will have a greater proportion of services that are higher risks). This would impact on comparisons.
- The activities (types of assessment) are also different across time periods, which means some financial years will have a greater proportion of activities that target specific risks/Quality Standards, instead of audits, again impacting comparisons.
- It is challenging to attribute changes to other reasons (such as contextual factors), or other potential reasons (new standards being introduced, a more rigorous approach to assessment by the Commission, and/or facilities being under pressure generally (due to COVID or other aged Care sector reforms)).

FINANCIAL YEAR	COUNT OF 8.C NOT MET	COUNT OF 8.C MET	COUNT OF 7.C NOT MET	COUNT OF 7.C MET	COUNT OF 3.G NOT MET	COUNT OF 3.G MET
2019–20	22%	78%	13%	87%	6%	94%
2020–21	37%	63%	28%	72%	32%	68%
2021–22	33%	67%	21%	79%	23%	77%
2022–23	19%	81%	9%	91%	8%	92%

Source: BBP, Data extracted 5 October 2023

10 APPENDICES

Complaints data

IPC-related complaints made to ACQSC 2019/20 to 2022/23.

All complaints made to the Commission are allocated a keyword and sub-keyword; however, a single complaint can cover several topics and can be recorded against several keywords and sub-keywords.

Data has been filtered to include only keywords and sub-keywords related to IPC as per below.

Keywords:

- Health Care
- COVID-19
- Personal Care

Sub-keywords

- Personal safety & Interventions
- Infectious diseases/infection control
- Concerns about preparedness & prevention
- Advice Service is in lockdown
- Social isolation
- Isolation – Infection Control
- Visitor restriction
- Concerns about flu vaccinations
- COVID Vaccine – Consent (Introduced 2020/21 Financial Year)
- COVID Vaccine – Residents (Introduced 2020/21 Financial Year)
- COVID Vaccine – Staff (Introduced 2020/21 Financial Year)
- COVID Vaccine – Visitors (Introduced 2020/21 Financial Year)
- Lack of communication

COMPLAINT KEYWORDS	2019–20	2020–21	2021–22	2022–23
COVID-19 related keywords	910	994	1282	351
Advice service is in lockdown	0	3	60	2
Concerns about flu vaccinations	41	22	15	2
Concerns about preparedness & prevention	179	338	278	136
COVID Vaccine – Consent	0	4	25	11
COVID Vaccine – Residents	0	21	37	11
COVID Vaccine – Staff	0	2	45	11
COVID Vaccine – Visitors	0	1	75	8
Isolation – Infection control	42	56	151	65
Lack of communication	1	72	123	28
Social isolation	42	5	72	15
Visitor restriction	605	470	401	62
Health Care related key words	613	773	231	174
Infectious diseases/infection control	613	773	231	174
Personal Care related keywords	218	237	229	171
Personal safety & Interventions	218	237	229	171

10 APPENDICES

COMPLAINT KEYWORDS	2019-20	2020-21	2021-22	2022-23
Total number of key words in complaints	1741	2004	1742	696
Total number of individual complaints	1380	1498	1432	611

Source: ACCMIS, data extracted 5 October 2023

IPC Capability Survey 2023: Relative risk of an outbreak with no IPC Lead

The relative risk of an outbreak for COVID-19, influenza, or gastroenteritis for an aged care home with an IPC Lead or no IPC has been calculated in the table below based on the respondents to the ACQSC IPC Capability Survey 2023. The period of reported outbreaks is assumed to be within the last 12 months of the survey (conducted in August 2023).

OUTBREAKS	AGED CARE HOMES WITH AN IPC LEAD	AGED CARE HOMES WITH NO IPC LEAD	RELATIVE RISK
Influenza			
Had an outbreak	124	4	
Zero outbreaks	1808	36	
Relative risk of having an outbreak if no IPC Lead	0.064	0.100	1.6 Increased risk
Gastroenteritis			
Had an outbreak	439	7	
Zero outbreaks	1498	33	
Relative risk of having an outbreak if no IPC Lead	0.227	0.175	0.8 Decreased risk

OUTBREAKS	AGED CARE HOMES WITH AN IPC LEAD	AGED CARE HOMES WITH NO IPC LEAD	RELATIVE RISK
COVID-19			
Had an outbreak	1732	35	
Zero outbreaks	199	5	
Relative risk of having an outbreak if no IPC Lead	0.897	0.875	1.0 No effect of risk

10 APPENDICES

APPENDIX C AGED CARE SECTOR GROUPS INVITED FOR CONSULTATION

Aged care sector stakeholder groups were invited to participate in consultations to understand the benefits of the IPC Lead role. Factors impacting the implementation and delivery of the IPC Lead program were also discussed to understand the impact and sustainability of the program.

STAKEHOLDER GROUP	STATUS
IPC Lead roles (current and former)	consulted
Aged care homes (case studies)	consulted
Workforce and sector groups	
Aged & Community Care Providers Association	consulted
Australian Nursing and Midwifery Federation	consulted
National Aboriginal Community Controlled Health Organisation	Unable to schedule a time
Federation of Ethnic Communities Councils of Australia	No response
Registered training provider	
ACIPC	consulted
Regulatory agencies	
ACQSC	consulted
ACSQHC	consulted
Consumer advocacy groups	
Carers Australia	consulted
Council on the Ageing (COTA) Australia	consulted

Dementia Australia	consulted
Palliative Care Australia	consulted
National Seniors Australia	No response
Older Persons Advocacy Network (OPAN)	Declined
Aged care providers	
Regis Aged Care Pty Ltd	consulted
Arcare Pty Ltd	consulted
Southern Cross Care	consulted
Anglicare Australia	No response
Baptist Care Australia	Referred to state branches, no responses
Catholic Health Australia	Unable to schedule a time
UnitingCare Australia	No response
Bupa Aged Care	No response
PHUs	
ACT Public Health Unit	consulted
VIC Loddon Mallee Public Health Unit	consulted
WA Metropolitan Public Health Unit	consulted

10 APPENDICES

APPENDIX D CASE STUDY SITE SELECTION CRITERIA AND SAMPLE FRAME

Table 10.2 presents the criteria used to develop the sample frame. (The sample frame to identify aged care homes to invite as a participant in the case studies is based on the criteria in Table 10.3. A sample frame reflective of all jurisdictions, provider types and size, and specialised services was developed to ensure an adequate cross-section of aged care homes was explored.) The key criteria elements are classified as either primary or secondary to inform the case study criteria selection. Each aged care home site selected for a case study must satisfy at least one primary criteria element, all primary criteria and each indicator must be represented. Each aged care home may have more than one primary criteria element plus a secondary criteria element. The sample frame of aged care homes with 'no IPC Lead' as the primary criteria element will be the only aged care homes with no IPC Lead. All other case study sites will have one or more IPC Lead.

Table 10.2: Aged care home case study criteria elements

	PRIMARY/SECONDARY CRITERIA	INDICATORS	RATIONALE FOR INCLUSION
Provider ownership type (Based on approved provider type classification)	Primary	Government organisations (state and territory owned) Not-for-Profit (includes community-based, religious, and charitable) For-profit	All aged care residential facilities are required to implement an IPC Lead role. Note: For the purposes of this evaluation, all approved providers.
MPS NATSIFAC	Primary	MPS NATSIFAC	MPS and NATSIFAC represent essential aged care service provider types for two key special needs groups – Aboriginal and Torres Strait Islander people and people in rural/remote areas: <ul style="list-style-type: none"> MPS provides integrated health and aged care services to regional and remote communities in areas that can't support both a separate aged care service and health service. NATSIFAC services provide culturally appropriate aged care to older Aboriginal and Torres Strait Islander peoples and deliver a mix of aged care services.
Remoteness	Primary	MMM 1 – Metropolitan MMM 2 – Regional MMM 3–5 – Rural MMM 6–7 – Remote	All aged care residential facilities are required to implement an IPC Lead that is dedicated and on-site. The challenges associated with geography – workforce, supply chain, technology, and operational models – will be explored to understand any impact on the implementation and operation of the IPC Lead program.

10 APPENDICES

	PRIMARY/SECONDARY CRITERIA	INDICATORS	RATIONALE FOR INCLUSION
Jurisdiction	Primary	VIC / NSW / ACT / QLD / NT / WA / SA / TAS	All aged care residential facilities in Australia are required to implement an IPC Lead role.
No IPC Lead	Primary	No IPC Lead reported	2% of aged care homes have not reported implementation of an IPC Lead; case study interviews will explore the barriers and challenges to the recruitment of an IPC Lead, and any other factors. A broad comparison of IPC practices in an aged care home (with similar characteristics) with an IPC Lead may also provide insight into any operational and/or setting that highlights an exception to the need for a dedicated on-site IPC Lead.
Special needs ⁵ groups	Primary	CALD / Homeless / Veterans / LGBTI / Other special needs group	OPAN's submission to the Royal Commission into Aged Care Quality and Safety argued that equitable access to culturally and socially appropriate aged care for people who are within special needs groups requires additional support and resourcing to be a priority ⁶ . Selection of one or more aged care homes that provide specialised support to one or more special need groups will explore any challenges associated with implementing IPC practices in a specialised aged care home and any subsequent impact on IPC Lead requirements.
Aged care home size (Number of beds)	Secondary	≤ 30 / 31–60 / 61–90 / 91–120 / > 120	The size of an aged care home will likely be an influencing factor in the number of IPC Lead roles implemented.
IPC Lead role type	Secondary	RNs / EN	An IPC Lead may be an RN or EN. Interviews with IPC Leads (during case study site visits) will explore any differences in factors influencing the uptake of the IPC Lead role. Interviews with aged care home operational representatives will explore the factors influencing the recruitment of an RN or EN to the IPC Lead role.

⁵ **People with special needs as defined in the Aged Care Act 1997** (Aboriginal and Torres Strait Islander, CALD, people who live in rural or remote areas, financially or socially disadvantaged, veterans, homeless or at risk of becoming homeless, care-leavers, parents separated from their children by forced adoption or removal, LGBTI, people of a kind (if any) specified in the Allocation Principles)

⁶ **OPAN, Special Needs in Aged Care and Advocacy**, Submission to Royal Commission into Aged Care Quality and Safety 20 September 2019
<https://agedcare.royalcommission.gov.au/system/files/2020-07/AWF.001.04275.pdf>

10 APPENDICES

	PRIMARY/SECONDARY CRITERIA	INDICATORS	RATIONALE FOR INCLUSION
Number of IPC Lead roles	Secondary	One / Two or more	The FTE of IPC Leads is not currently reported by aged care homes. The IPC Lead configurations – single, multiple, FTE – will be explored in aged care home case studies to further understand the implementation and operating models of the IPC Lead program.
IPC Training Grant uptake	Secondary	Approved / Not received	To explore the drivers and any disincentives or perceptions influencing the uptake of the IPC Training Grant.
Secure dementia (or other behavioural conditions) care	Secondary	Yes	To explore any challenges associated with the implementation of IPC practices in an aged care home with secure care facilities and any subsequent impact on IPC Lead requirements.

The sample frame to identify aged care homes to invite as a participant in the case studies is based on the criteria in Table 10.3. A sample frame reflective of all jurisdictions, provider types and size, and specialised services was developed to ensure an adequate cross-section of aged care homes was explored.

Table 10.3: Aged care home case study sample frame

AGED CARE HOME CASE STUDY NUMBER	PRIMARY ELEMENT	PRIMARY ELEMENT INDICATORS	SECONDARY ELEMENT	SECONDARY ELEMENT INDICATORS
1	Provider type	Government organisation	Remoteness	MMM 2 – Regional
	Jurisdiction	VIC	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One
			Aged care home size (Number of beds)	≤ 30
2	Provider type	Government organisation	Remoteness	MMM 3–5 – Rural
	Jurisdiction	SA	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One

10 APPENDICES

AGED CARE HOME CASE STUDY NUMBER	PRIMARY ELEMENT	PRIMARY ELEMENT INDICATORS	SECONDARY ELEMENT	SECONDARY ELEMENT INDICATORS
			Aged care home size (Number of beds)	≤ 30 / 31-60
3	Provider type	For-profit	Remoteness	MMM 1 – Metropolitan
	Jurisdiction	NSW	IPC Lead role type	RNs
			Number of IPC Lead roles	Two or more
			Aged care home size (Number of beds)	> 120
			Secure dementia (or other behavioural conditions) care	Yes
4	Provider type	For-profit	Remoteness	MMM 2 – Regional
	Jurisdiction	QLD	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One
			Aged care home size (Number of beds)	91-120 / > 120
5	Provider type	For-profit	Remoteness	MMM 3-5 – Rural
	Jurisdiction	VIC	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One
			Aged care home size (Number of beds)	31-60
	Special needs groups	LGBTIQ		
6	Provider type	For-profit	Remoteness	MMM 3-5 – Rural
	Jurisdiction	SA	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One or more

10 APPENDICES

AGED CARE HOME CASE STUDY NUMBER	PRIMARY ELEMENT	PRIMARY ELEMENT INDICATORS	SECONDARY ELEMENT	SECONDARY ELEMENT INDICATORS
			Aged care home size (Number of beds)	31–60 / 61–90
7	Provider type	For-Profit	Remoteness	MMM 2 – Regional
	Jurisdiction	TAS	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One
			Aged care home size (Number of beds)	31–60 / 61–90 / 91–120
8	Provider type	Not-for-Profit	Remoteness	MMM 6–7 – Remote
	Jurisdiction	WA	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One or more
			Aged care home size (Number of beds)	61–90 / 91–120
9	Provider type	Not-for-Profit	Remoteness	MMM 1 – Metropolitan
	Jurisdiction	NSW	IPC Training Grant uptake	Approved
	Special needs groups	Veterans	Number of IPC Lead roles	One / Two or more
10	Provider type	Not-for-Profit	Remoteness	MMM 1 – Metropolitan
	Jurisdiction	WA	Number of IPC Lead roles	One / Two or more
	Special needs groups	Homeless		
11	Provider type	Not-for-profit	Remoteness	MMM 1 – Metropolitan
	Jurisdiction	SA	IPC Lead role type	RNs / EN
	Special needs groups	CALD	Number of IPC Lead roles	One or more
			Aged care home size	91–120 / > 120

10 APPENDICES

AGED CARE HOME CASE STUDY NUMBER	PRIMARY ELEMENT	PRIMARY ELEMENT INDICATORS	SECONDARY ELEMENT	SECONDARY ELEMENT INDICATORS
			(Number of beds)	
12	Provider type	Not-for-profit	Remoteness	MMM 1 – Metropolitan
	Jurisdiction	ACT	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One / Two or more
			Aged care home size (Number of beds)	61–90 / 91–120
			IPC Training Grant uptake	Approved / Not received
13	Provider type	Not-for-profit	Remoteness	MMM 1
	Jurisdiction	NSW	IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One / Two or more
			Aged care home size (Number of beds)	61–90 / 91–120
			IPC Training Grant uptake	Approved / Not received
	Special needs groups	CALD		
14	Provider type	Not-for-profit	Remoteness	MMM 3–5 – Rural
	Jurisdiction	QLD	Aged care home size (Number of beds)	≤ 30 / 31–60 / 61–90
			IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One / Two or more
15	Provider type	Not-for-profit	Remoteness	MMM 2 – Regional

10 APPENDICES

AGED CARE HOME CASE STUDY NUMBER	PRIMARY ELEMENT	PRIMARY ELEMENT INDICATORS	SECONDARY ELEMENT	SECONDARY ELEMENT INDICATORS
	Jurisdiction	TAS	Aged care home size (Number of beds)	≤ 30 / 31-60 / 61-90 / 91-120 / > 120
			IPC Lead role type	RNs / EN
			Number of IPC Lead roles	One / Two or more
			IPC Training Grant uptake	Approved / Not received
			Secure dementia (or other behavioural conditions) care	Yes
16	MPS/NATSIFAC	MPS	Remoteness	MMM 6-7 – Remote
	Jurisdiction	WA		
17	NATSIFAC	NATSIFAC	Remoteness	MMM 6-7 – Remote
	Jurisdiction	NT		
No IPC Lead				
18A	MPS/NATSIFAC	MPS	Remoteness	MMM 6-7 – Remote
	Jurisdiction	WA		
18B	Provider type	For-profit	Remoteness	MMM 1 – metropolitan
	Jurisdiction	any		

Note: case study site 13 was removed in order to add an additional site with no IPC Lead. Of the sample frame of for-profit aged care homes registered with no IPC Lead, none intentionally had no IPC Lead. All were reportedly in transition between leads and/or newly opened and had now implemented one. Two additional aged care homes were engaged to be a case study site for breadth:

- For-profit, metropolitan, VIC
- Not-for-profit, metropolitan, NSW

10 APPENDICES

APPENDIX E IPC LEAD FRAMEWORK

IPC LEAD FRAMEWORK COMPONENT	GUIDANCE ON IPC LEAD ROLE ACTIVITIES AND SUPPORTS IN PLACE BY AGED CARE HOMES
IPC Lead role	<ul style="list-style-type: none"> • Guidance on the minimum FTE requirements to undertake the IPC Lead role (appropriate to the aged care home size and type) is required to enable the role to be used effectively and ensure business continuity in terms of access to IPC advice. • Dedicated FTE (allocated days and/or hours) to undertake IPC activities. • Dedicated time to undertake IPC professional development that may include: <ul style="list-style-type: none"> ○ Review of regulatory and legislative requirements relevant to IPC ○ Current best IPC practices ○ Communities of practice ○ Participation in peer support networks and/or activities • IPC Lead role description <ul style="list-style-type: none"> ○ Duties <ul style="list-style-type: none"> ▪ Support the aged care home to observe, assess and report on IPC processes and outcomes through compliance audits and participation in clinical governance committees. ▪ Support the aged care home with specialist advice to develop and periodically review policies and procedures (including outbreak management plans) in IPC which are reflective of best practices and current legislative and regulatory requirements. ▪ Support the aged care home with specialist advice to ensure compliance with the Aged Care Quality Standards, specifically concerning: <ul style="list-style-type: none"> • Standard 3 (3 (g)) • Standard 5 (3 (b)(c)) • Standard 7 (3 (c)) • Standard 8 (3 (d)(e)) ▪ Support the aged care home to coordinate and deliver education, competency and orientation focused on IPC for aged care staff. ▪ Support the aged care home to coordinate vaccination programs for staff and residents. ▪ Support the aged care home to promote antimicrobial stewardship. ▪ Provide clinical leadership in IPC to aged care staff to ensure delivery of high-quality care in a consumer-centred approach. ▪ Support the aged care home to ensure the best IPC practices and knowledge is in place for a safe, clean environment.

10 APPENDICES

IPC LEAD FRAMEWORK COMPONENT	GUIDANCE ON IPC LEAD ROLE ACTIVITIES AND SUPPORTS IN PLACE BY AGED CARE HOMES
	<ul style="list-style-type: none"> ▪ Undertake ongoing professional development in IPC. ○ Skills and experience <ul style="list-style-type: none"> ▪ Current AHPRA registration ▪ Bachelor of Nursing or Diploma of Nursing qualification ▪ Recognised postgraduate qualification in IPC (level AQF8) ▪ Effective communicator with demonstrated clinical leadership skills.
Personal care and clinical care	<ul style="list-style-type: none"> • The IPC Lead will support the aged care home to observe, assess and report on infection prevention and control processes and outcomes by undertaking and/or coordinating regular IPC compliance audits (e.g. IPC self-assessment checklists). <ul style="list-style-type: none"> ○ The aged care home may support the IPC Lead to undertake and/or coordinate regular IPC compliance audits through the provision of standardised organisational IPC audit tools. ○ The IPC Lead will report IPC compliance audit outcomes via documented internal organisation reporting pathways. • The IPC Lead will support the aged care home with specialist advice to develop and periodically review outbreak management plans (including COVID-19, gastroenteritis, and influenza) that are reflective of best practices and current legislative and regulatory requirements. <ul style="list-style-type: none"> ○ The IPC Lead will document and report on infectious diseases required to be notified to state or territory government authorities through internal organisation reporting pathways and/or directly to state or territory government authorities. ○ The aged care home will ensure contacts at relevant state or territory government departments that can help prepare for, identify, and manage any outbreaks are documented and readily available to IPC Lead(s). • The IPC Lead will support the aged care home to promote antimicrobial stewardship (AMS) through promoting and supporting: <ul style="list-style-type: none"> ○ AMS policy and processes for appropriate administration of antibiotics ○ Personal and clinical care to minimise the need for antibiotics e.g. measures to reduce the risk of urinary tract infections ○ The aged care home will draw in internal or external expertise (e.g. third-party consultancy) as required to support the education and training of IPC Leads and aged care staff in AMS. • The IPC Lead will support the aged care home to coordinate vaccination programs for staff and residents by: <ul style="list-style-type: none"> ○ Documenting workforce and resident vaccination programs ○ Liaising and coordinating with internal and/or external vaccination program service providers ○ Promoting the benefits of vaccinations to aged care staff and residents ○ The aged care home should ensure processes and/or systems are in place to evidence vaccination programs.

10 APPENDICES

IPC LEAD FRAMEWORK COMPONENT	GUIDANCE ON IPC LEAD ROLE ACTIVITIES AND SUPPORTS IN PLACE BY AGED CARE HOMES
Service environment	<ul style="list-style-type: none"> The IPC Lead will support the aged care home to ensure the best IPC practices and knowledge are in place for a safe, clean environment with a focus on: <ul style="list-style-type: none"> Cleaning materials and methods for the internal environment (aged care home) Furniture, fittings and equipment are safe and clean Single-use and single-consumer devices aren't re-used or shared The aged care home has arrangements with third-party contractors in place to ensure cleaning and/or equipment provided meets the aged care home IPC requirements.
Aged care workforce	<ul style="list-style-type: none"> The IPC Lead will support the aged care home to coordinate and deliver education, competency and orientation focused on IPC for aged care staff that includes: <ul style="list-style-type: none"> IPC training of aged care staff on commencement of employment and ongoing (annually and/or as required) The aged care home will draw in internal or external expertise (e.g. third-party consultancy) as required to support the education and training of IPC Leads and aged care staff in IPC The aged care home will document and evidence the skills and competency of its workforce The IPC Lead can be supported by IPC champions, i.e. aged care staff designated to undertake specific IPC activities to support the IPC Lead. For example, PPE stock expiry and level checks or hand hygiene compliance audits. The IPC Lead will provide clinical leadership in infection, prevention, and control to aged care staff to ensure the delivery of high-quality care in a consumer-centred approach. <ul style="list-style-type: none"> The aged care home will support and reinforce IPC practices and news through regular communication channels (e.g. staff meetings, email/app communications).
Organisational governance	<ul style="list-style-type: none"> The IPC Lead will be a member of and actively participate in the aged care home clinical safety and quality governance committee and/or working/advisory group. The IPC Lead will undertake and/or support mandatory IPC-related reporting to state and territory government authorities. The IPC Lead will document IPC risks and mitigation strategies, clinical incidents, and audit outcomes in aged care home risk management systems. <ul style="list-style-type: none"> The aged care home has systems for identifying risks and incidents, minimising and managing risks and responding to incidents to support the safety and wellbeing of consumers.
Consumer engagement	<ul style="list-style-type: none"> The IPC Lead will support the development and communication of IPC risks and advice to residents and visitors (families, carers, friends) that includes: <ul style="list-style-type: none"> Notifying family/carers/friends of any outbreaks and action plans (e.g. visitor restrictions) Education sessions on the benefits of vaccination programs

10 APPENDICES

IPC LEAD FRAMEWORK COMPONENT	GUIDANCE ON IPC LEAD ROLE ACTIVITIES AND SUPPORTS IN PLACE BY AGED CARE HOMES
	<ul style="list-style-type: none">○ The aged care home will support and reinforce IPC risks, practices, and news through regular communication channels (emails, newsletters, text messages, aged care home signs) to residents and family/carers/friends.

10 APPENDICES

APPENDIX F REFERENCES

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10 APPENDICES

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