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Aged Care Quality and Safety Commission

ACQSC QAMG Education

AMS and the Antimicrobial Stewardship Self-Assessment tool

s.22(1)(a)(ii), Infectious Diseases physician

January 2024

Session

- Why antimicrobial use is a focus for improvement in RACS
- AMS – what is it and how does it address antimicrobial use
- AMS and the Quality Standards
- AMS in RACS – what does the ideal look like
- AMS Self-Assessment tool
- ACQSC To Dip or Not to Dip quality improvement intervention for RACS
- Q & A session

ACQSC Complaints 2019-2020

Of all medication-related complaints

- 10% related to infectious disease
- Third most common complaint after pain/palliative care and sedatives

Infectious diseases clinical indications or other

53.7%	**Urinary tract**
11.1%	**Skin**
9.3%	**Eye**
5.6%	Respiratory
1.9%	Allergymismatch
18.7%	Administration: clinical indication unspecified

Of urinary tract indications;

35% **Recurrent UTI**

One-quarter relating to service not adequately monitoring for recurrent UTI, followed by service not diagnosing UTI in timely fashion

24% Inadequate or lack of clinical review

Lim L, Breen J. National Medicines Symposium 2021

Antimicrobials – A focus for improvement in aged care services

Antimicrobial use in aged care services

- At any point in time 10% of residents are on an antimicrobial
- 70% of residents are prescribed at least one antimicrobial course a year (2X higher than community)
- 20% of prescriptions are for prophylaxis

Aged Care National Antimicrobial Prescribing Survey (AC-NAPS 2021)

- Prolonged duration of prescriptions (42% >6 months)
- High rates of "PRN" prescriptions (topical >oral antimicrobials)

National surveillance reports (AURA 2023)

Antimicrobial resistance rates	Aged Care	Community	Hospitals
Staphylococcus aureus methicillin-resistance	26%	17%	21%
Escherichia coli cefazolin-resistance	37%	17%	20%

Antimicrobial use – What are the problems?

Indication

Clinical/undifferentiated syndromes that may not require antibiotics

Fall, acute behaviour change

Viral infections

-Sore throat, sinusitis, conjunctivitis

Conditions mistaken as infection

-Asymptomatic bacteriuria (“ASB”)

Performing low-value tests & treating the test result rather than the person

- Urine dipstick, skin swabs of uninfected wounds

Poor documentation of reason for prescribing

“There was a resident with frequent falls…We did a dipstick which was positive, then MSU, so we diagnosed UTI.”

Choice

Excessive use of antibiotics, including broad-spectrum agents

Prescribing use of antimicrobials prescribed as “when required” (PRN) e.g. topical antifungals

Duration

Excessive durations for treatment of infections

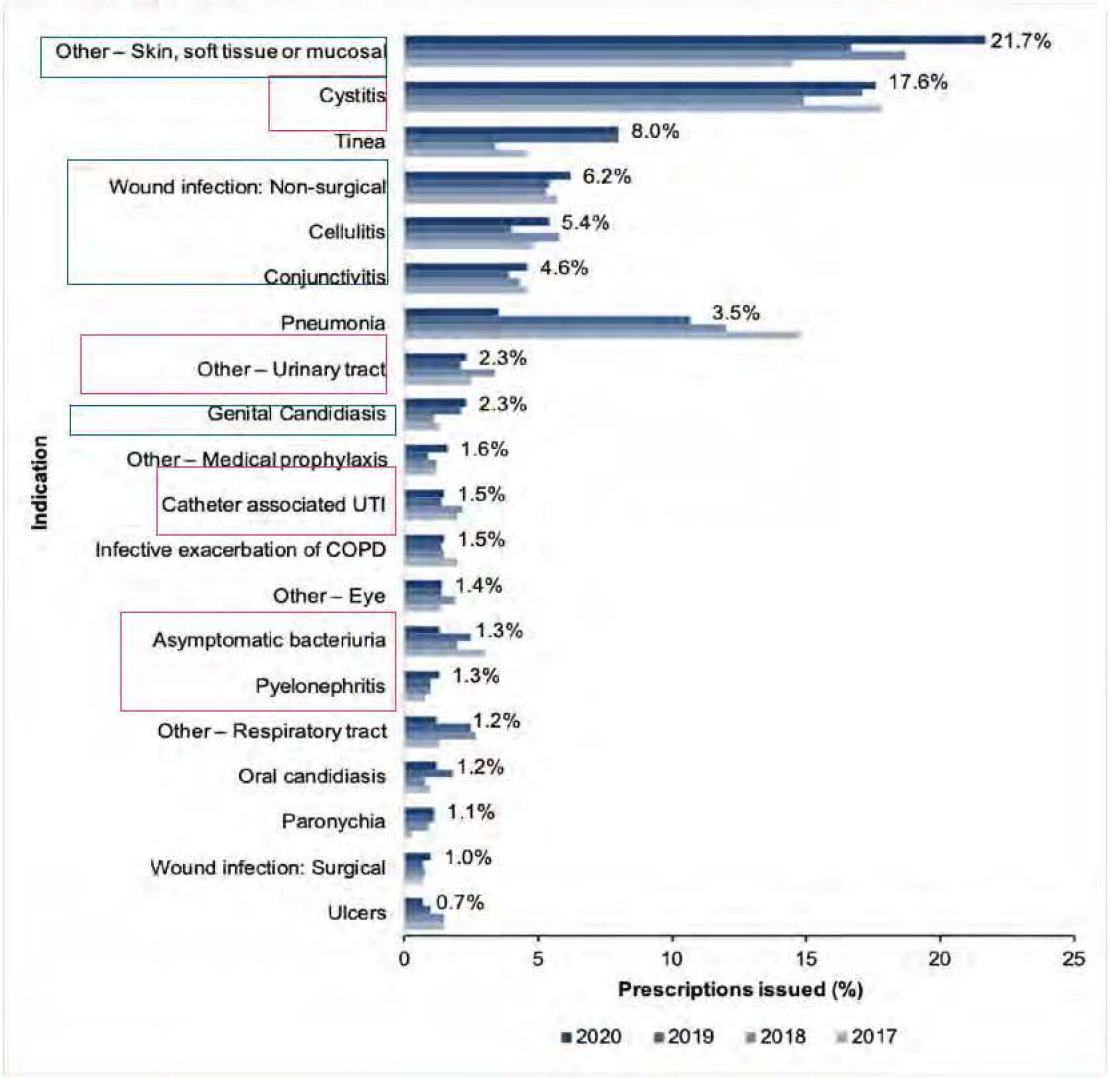
Excessive durations for prevention of infections

Aged Care NAPS

Prescribing for UTI or UTI-related conditions

Oral antibiotics

Figure 8: Most common indications for antimicrobial prescriptions, Aged Care NAPS contributors, 2017–2020



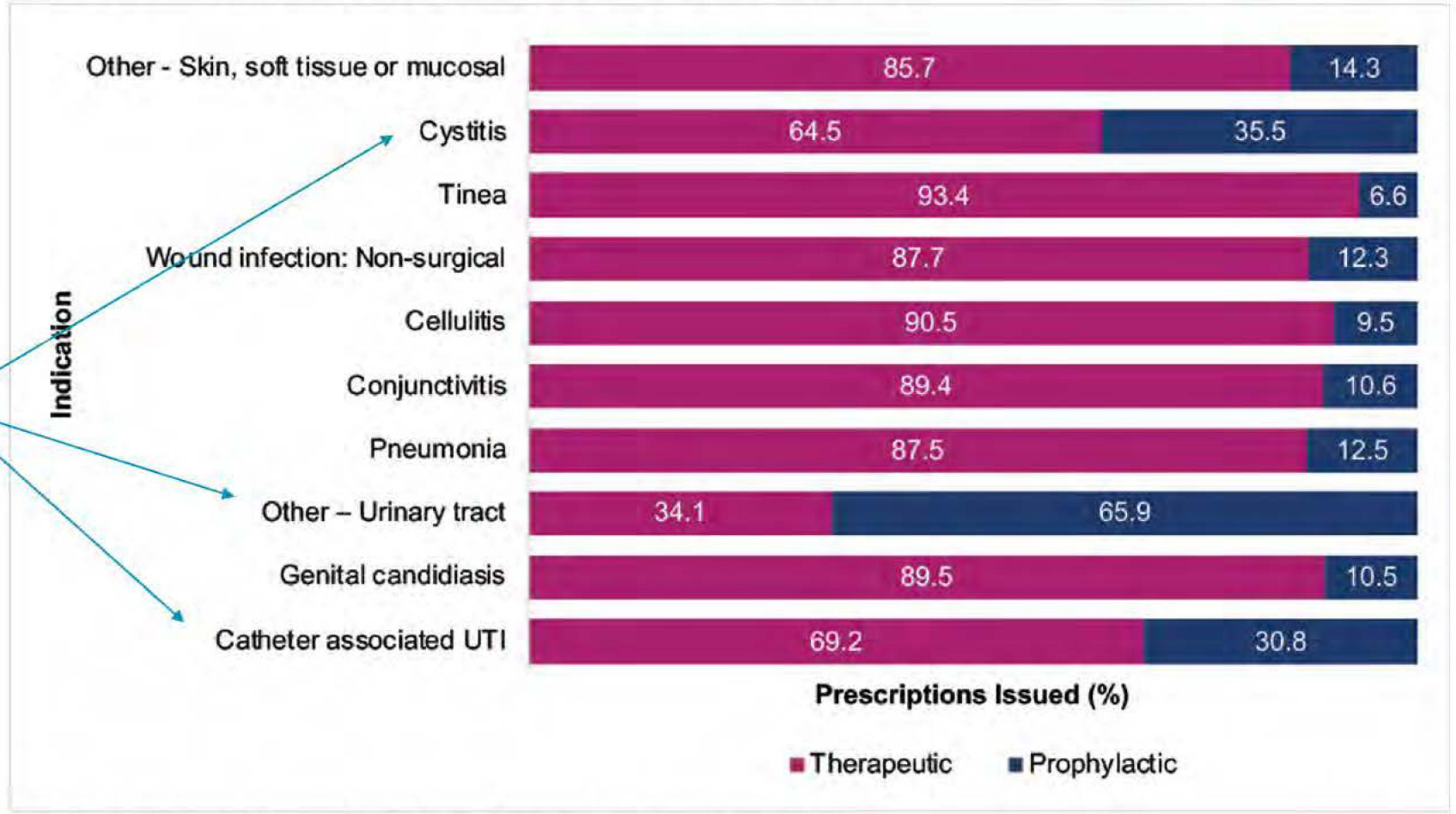
Prescribing for skin/soft tissue/mucosal

Topical > oral antimicrobials

Prescribing – Issues with duration

Figure 10: Comparison of therapeutic and prophylactic antimicrobial prescriptions for common indications, Aged Care NAPS contributors, 2020

High proportion of prophylaxis prescriptions



Source: Antimicrobial and infection form Section 2, Method 1 and 2 data

Table 2 Prescribing practices for prophylactic antimicrobials

Measurement	Systemic antimicrobials only	
	Prophylactic ($n=4047$)	
	No.	%
Frequency		
pro re nata	86	2.1
Duration		
>6 months	2170	53.6
≤6 months	1643	40.6
Unknown	234	5.8
Documentation		
Indication	2653	65.6
Review or stop date	759	18.8
Proportion	4047	42.3

[a]Includes prophylactic and therapeutic antimicrobials

Poor documentation contributes to excessive duration

Drugs - Real World Outcomes (2022) 9:561–567
https://doi.org/10.1007/s40801-022-00323-5

ORIGINAL RESEARCH ARTICLE

Prophylactic Antimicrobial Prescribing in Australian Residential Aged-Care Facilities: Improvement is Required

Noleen Bennett[1,2,3,4] · Michael J. Malloy[2,3,5] · Rodney James[1,3,6] · Xin Fang[1,3] · Karin Thursky[1,3,6] · Leon J. Worth[2,3,6]

- AC NAPS data 2016-2020
  - Over 1100 RACFs
  - 126,137 residents

Antimicrobial Stewardship – What is it?

Careful and responsible management of antimicrobials used to treat or prevent infections

Be able to

- **detect serious infections and institute appropriate management in a timely manner (in the context of the person's goals and wishes)**
- **avoid unnecessary antimicrobial use and**
- **reduce antimicrobial resistance**

AMS is undertaken by healthcare organisations by implementing an AMS program

Provider obligations around AMS – Quality Standards

Standard 3 requirement (3) (g)

Minimisation of infection-related risks through implementing:

(i) standard and transmission-based precautions to prevent and control infection and

(ii) practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

Standard 8 requirement (3)(e)

Where clinical care is provided – a clinical governance framework including but not limited to the following:

(i) antimicrobial stewardship

(ii) minimising the use of restraint

Standard 8 requirement (8)(e)

Effective organisation wide systems are required for preventing, managing and controlling infections and antimicrobial resistance.

Draft strengthened Aged Care Quality Standards (Nov 2023)

Outcome 5.2: Preventing and controlling infections in clinical care

Outcome statement:

Older people, workers, health professionals and others are encouraged and supported to use antimicrobials appropriately to reduce risks of increasing resistance.

Infection risks are minimised and, if they occur, are managed effectively.

Actions:

5.2.1 The provider implements an antimicrobial stewardship system relevant to the service context and consistent with national guidance.

5.2.2 The provider implements processes to:

a) perform clean procedures and aseptic techniques

b) minimise infection when using and managing invasive devices.

Defines AMS as “an on-going effort by a provider to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It can include a broad range of strategies, such as monitoring and reviewing how antimicrobials are used”.

Draft strengthened Aged Care Quality Standards (Nov 2023)

Outcome 5.3: Safe and quality use of medicines
Outcome statement:

Older people, workers and health professionals are encouraged and supported to use medicines in a way that maximises benefits and minimises the risks of harm.

Medicines are appropriately and safely prescribed, administered, monitored and reviewed by qualified health professionals, considering the clinical needs and informed decisions of the older person.

Medicines-related adverse events are monitored, reported and used to inform safety and quality improvement.

5.3.2 The provider has processes to ensure medication reviews are conducted including:

a) at the commencement of care, at transitions of care and annually when care is ongoing

b) when there is a change in diagnosis or deterioration in behaviour, cognition or mental or physical condition or when a person is acutely unwell

c) when there is polypharmacy and the potential to deprescribe

d) when a new medicine is commenced, or a change is made to an existing medicine or medication management plan

e) when there is an adverse event potentially related to medicines.

5.3.3 The provider documents existing or known allergies or side effects to medicines, vaccines or other substances at the commencement of care and monitors and updates documentation when new allergies or side effects occur.

5.3.4 The provider implements processes to identify, monitor and mitigate risks to older people associated with the use of high-risk medicines, including reducing the inappropriate use of psychotropic medicines.

5.3.6 The provider regularly reviews and improves the effectiveness of the system for the safe and quality use of medicines.

National Aged Care Mandatory Quality Indicator Program (QI Program)
Manual 3.0 – Part A

TABLE 13: MEDICATION MANAGEMENT – POLYPHARMACY QUALITY INDICATOR OVERVIEW

Percentage of care recipients who were prescribed nine or more medications

COLLECTION

- A single review of medication charts and/or administration records for each care recipient on a selected collection date every quarter

QUALITY INDICATOR REPORTING

- Care recipients who were prescribed nine or more medications

ADDITIONAL REPORTING

- Care recipients assessed for polypharmacy
- Collection date

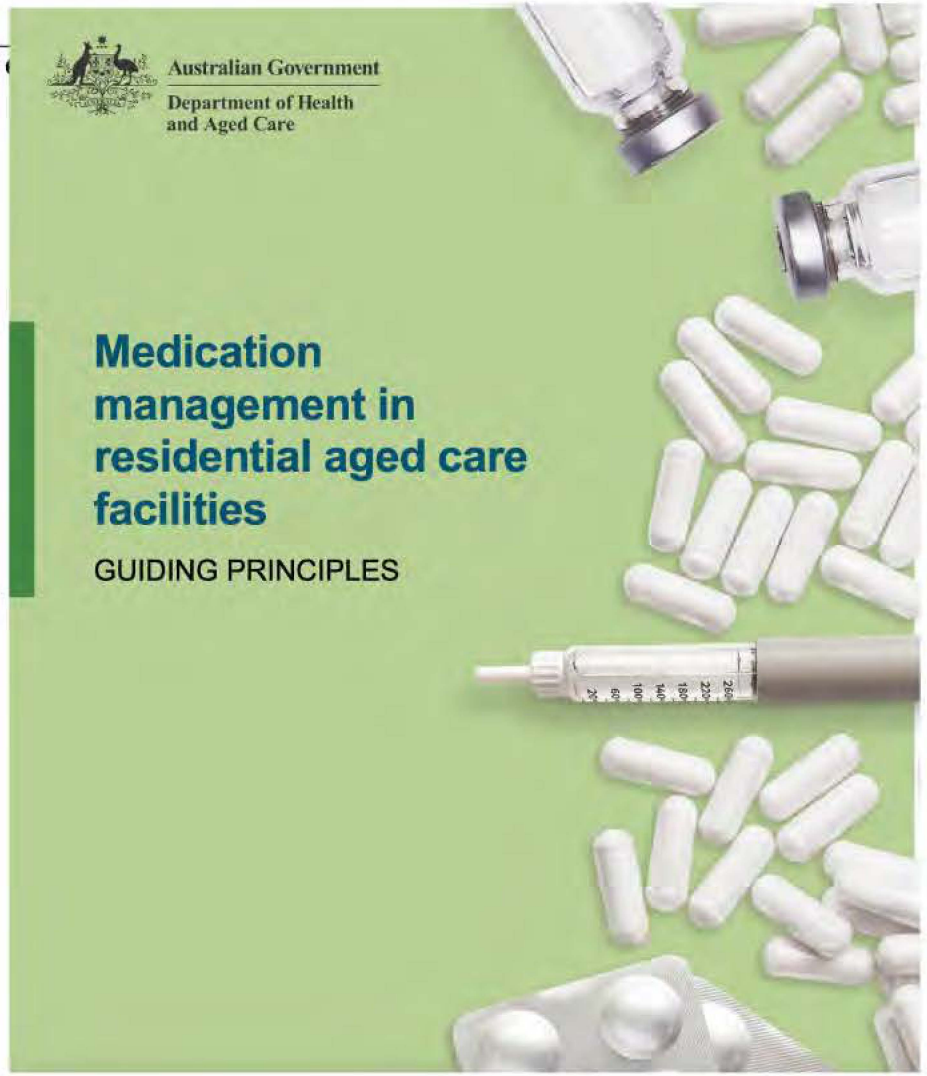
Exclusions:

- Care recipients admitted in hospital on the collection date

For the purposes of the QI Program, polypharmacy is defined as the prescription of nine or more medications to a care recipient.

For the purposes of the QI Program, any medication with an active ingredient is counted in the polypharmacy quality indicator, except for those listed below which must not be included in the count of medications:

- **Lotions, creams or ointments used in skin and wound care;**
- **Dietary supplements, including those containing vitamins;**
- **Short-term medications, such as antibiotics or temporary eye drops; and**
- **PRN medications.**



Guiding Principle 3: Clinical governance of medication management

The RACF has systems and processes that are used to support and promote safe and effective management of the quality use of medicines within the facility.

Medicines governance group

- medication advisory committee (MAC)
- position within the organisational structure
- responsibility for implementing and monitoring the decisions of the MAC needs to be clearly defined
- membership multidisciplinary, must include senior staff member
- implementation remains the responsibility of the organisation's Executive management or is delegated to a pharmacist
- It may be impractical for a small aged care facility to have its own MAC, the RACF may be represented at and function under the MAC governance of a larger organisation or aged care provider

MACs role

1. Develop and endorse policies, procedures and guidelines and advise on legislation and standards
2. Advise on risk-management systems associated with medication management
3. Identify education and training needs for medication management
4. Monitor effectiveness and performance as well as implement quality improvement strategies for medication management

Potential policies, procedures and guidelines relating to medication management for RACFs

- Antimicrobial stewardship and infection control
- Managing deprescribing and the use of 'deprescribing guides'
- Medication review

An AMS program in RAC – What does the ideal look like?

AMS framework to support best antimicrobial prescribing in aged care					
Leadership	**Accountability**	**Resources to support best practice**	**Surveillance**	**Action**	**Education and Communication**
Commit to preventing infections and improving anti-microbial use	Individuals accountable for AMS activities, a multi-disciplinary AMS team	Policies, processes or guidelines Access to individuals with antimicrobial expertise Access to evidence based prescribing guidelines Access to pathology results	Track process measures Track outcome measures Disseminate surveillance reports Audit and feedback	Implement AMS policies and practices Regular program review to identify areas for improvement Quality improvement activities	AMS education, training and communication to staff AMS education and communication to residents and families Communication with GP

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ACQSC AMS Self- Assessment Tool

The AMS SAT has been developed to help services to review AMS activities undertaken and their contribution towards an AMS program. **The AMS SAT is not intended for use as a benchmarking tool for comparison between services or as a Commission assessment tool.**

AMS SAT in RACS

- to support the development and implementation of AMS programs
- to support AMS continuous improvement
- to support clinical, Infection Prevention and Control Leads and committees with oversight of AMS in RACS (e.g. Medication Advisory Committees)
- to support review of current AMS activities undertaken and their contribution towards an overall program
- to identify new gaps and areas for improvement

AMS SAT

- tool accompanied by a user guide
- will be available on ACQSC AMS webpage
- tool is aligned with recommendations by the Antimicrobial Stewardship in Australian Health Care (the AMS Book)

Structure

Framework of an AMS program - 7 core components

Each core component has a menu of activities

Using the AMS SAT

1. Get team together to complete the tool as a group
2. Gather existing evidence and undertake a gap analysis
3. Use findings to update the AMS program action plan
4. Repeat this periodically as part of continuous improvement

Using AMS SAT

Step 1:
Complete the tool as a group

- Undertaken by a group of healthcare professionals directly involved in AMS and quality and safety and including a range of people from different professional groups (e.g. nursing, operational, pharmacists, general practitioners)
- Include it as a periodic review annual activity by the committee with oversight of AMS in RACS or by the service AMS team for briefing to the committee.

Step 2:
Gather existing evidence and undertake a gap analysis

- For questions that received a “yes” response, review the type and quality of evidence and determine if sufficient to justify the answer.
- For questions that received a “no” response”, consider how this may translate to a gap in practice and identify risks and shortfalls. Review and update your plan for continuous improvement in response to identified risks and shortfalls.

Step 3:
Update the AMS program action plan

- The AMS program action plan is a rolling document that details AMS priorities, and planned actions for improving AMS in the facility.

Step 4:
Repeat the cycle periodically

- Steps 1 to 3 should be repeated periodically (e.g. annually) as part of the service’s program for AMS program continuous improvement

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Structure

Core components of an AMS program

1. AMS committee resources and governance - 14 items
2. Education and training - 6 items
3. AMS policies, procedures and guidelines – 10 items
4. Minimising risks of antimicrobial usage – 6 items
5. Monitoring AMS activities through auditing and surveillance – 10 items
6. Reporting with feedback – 5 items
7. Consumers – 4 items

1	Antimicrobial Stewardship (AMS) committee resources and governance	Yes/No	If yes, what is the evidence?	If no, is this a gap? What is the plan to address?
1.1	Do you have a multidisciplinary committee (e.g. Medication Advisory Committee) for oversight of AMS governance at a service-level which includes the following: clinician (e.g. lead RN, IPC Lead, clinical manager), general practitioner or nurse practitioner, pharmacist?			
1.2	Does the committee with AMS oversight have service-level representation from AMS Lead and/or IPC Lead?			
1.3	Does the committee with AMS oversight have reporting obligations (e.g. provision of action plans as part of Continuous Improvement, quality activity results or meeting minutes) to executive and clinical governance committees? Does it receive acknowledgment and feedback from the committee/s on receipt of report?			
1.4	Does the committee with AMS oversight meet regularly (e.g. 3-monthly)?			
1.5	Does the committee with AMS oversight produce minutes and an action list?			
1.6	Does the committee with AMS oversight develop or have oversight on service-level action plans (e.g. Plan for Continuous Improvement) to address issues raised by monitoring of AMS activities (e.g. antimicrobial usage surveillance or audits)?			
1.7	Are AMS action plans (e.g. Plan for Continuous Improvement) shared with service-level management, to support operationalising actions at a service level?			

1.8	Are the committee's meeting minutes and/or action plans shared with the service Infection Prevention and Control leads (if they are not a member of this group)?			
1.9	Does the committee use the Aged Care Quality and Safety Commission's resources to support AMS in the service? (e.g. ACQSC's Guidance and resources for providers to support Aged Care Quality Standards)			
1.10	Does your service or organisation refer to, and implement, recommendations from the ACSQHC Antimicrobial Stewardship Clinical Care Standard when planning and implementing AMS activities? (https://www.safetyandquality.gov.au/our-work/clinical-care-standards/antimicrobial-stewardship-clinical-care-standard)			
1.11	Does your service have an IPC or AMS team that includes persons responsible for aspects of AMS governance and program implementation (e.g. AMS nurse lead, RN representative on committee with AMS oversight, pharmacist)? Is there a team lead responsible for implementation of service-level AMS initiatives and day-to day running of the AMS program? Are the committee's meeting minutes and decisions shared with this team?			
	Do you have a service-level AMS action plan showing current AMS initiatives? Is this plan endorsed by the committee with AMS			

- For questions that received a "yes" response, review the type and quality of evidence and determine if sufficient to justify the answer. Examples of reflection questions are provided in the Aged Care Quality and Safety Commission's Guidance and resources for providers to support Aged Care Quality Standards.
- For questions that received a "no" response", consider how this may translate to a gap in practice and identify risks and shortfalls.

2	Education and Training
2.1	Is there an annual calendar of AMS Education and Training activities for, but not limited to, nursing and personal carer staff within the service? Is it evaluated at least every 2 years?
2.2	Does the AMS lead have additional training in one of the following areas: infection prevention and control, antimicrobial stewardship? (e.g. from a foundation Aged Care IPC Lead course)
2.3	Is the AMS lead allocated time and resources to provide continuing education in infectious diseases, antimicrobial use, or AMS?
2.4	Are clinical staff informed about peer-reviewed, endorsed, evidence-based guidelines for treatment of common infections such as urinary tract infections, skin infections, pneumonia, viral respiratory tract infections (e.g. COVID-19, influenza)? (e.g. Therapeutic Guidelines)
2.5	Do relevant clinical staff receive education or updates (e.g. printed or electronic information) about antimicrobial prescribing and/or relevant best practice guidelines regularly (e.g. annually)?
2.6	Do antimicrobial prescribers (general practitioners, nurse practitioners) have access to current information about formulary and/or relevant best

3	Antimicrobial Stewardship (AMS) policies, procedures and guidelines
3.1	Are the roles, responsibilities, and expectations of relevant health professionals (nurses, IPC Leads, personal care staff, prescribers, care managers) in relation to AMS clearly defined in an AMS policy?
3.2	Do you have a written policy establishing best practice principles for antimicrobial prescribing and utilisation?
3.3	Do you have a written policy or procedure establishing best practice principles for infection identification and management?
3.4	Is there document/version control for currency of all AMS policies and guidelines?
3.5	Does a written policy or procedure stipulate that antimicrobial indication should be recorded for all prescribed antimicrobials (e.g. in medication chart and notes, or in medication chart, or in notes)?
3.6	Does a written policy or procedure stipulate that antimicrobial course length or review date is recorded at time of prescribing (e.g. in medication chart and notes, or in medication chart, or in notes)?
3.7	Does a written policy or procedure stipulate that all prescriptions of antimicrobial therapy are appropriately reviewed and by whom after microbiology results are available?

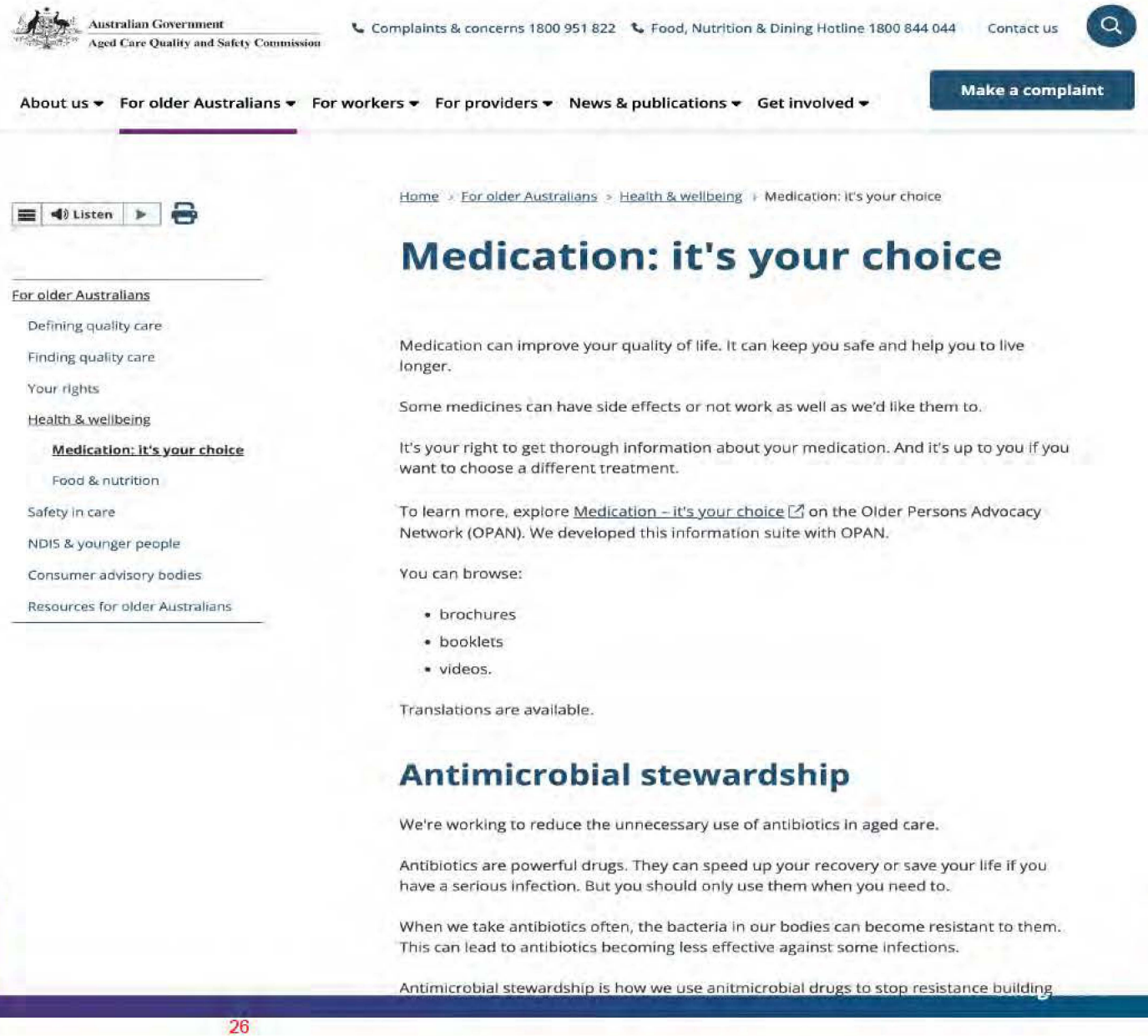
4	Minimising risks of antimicrobial usage
4.1	Do you have guidelines that provide recommendations for treatment of consumers with antimicrobial allergies? (e.g. refer to Therapeutic Guidelines: Antibiotic)
4.2	Do you have guidelines for appropriate documentation of adverse drug reactions, including antimicrobial allergies?
4.3	Does you have guidance available for administration of medications that can or cannot be safely crushed, alternative formulations (e.g. liquid antimicrobials) including antimicrobial Product Information, local guidelines for specific agents?
4.4	Do you undertake service-level AMS quality improvement activities to address antimicrobial overprescribing? (e.g. To Dip or Not to Dip)
4.5	Are pharmacists available at your service to assist with prescribing when or if required?
4.6	Are adverse events associated with antimicrobial use (e.g. drug-allergy mismatch, *C. difficile* infection), recorded through Incident Management System or similar?

5	Monitoring AMS activities through auditing and surveillance
5.1	Do you review and update your AMS auditing and surveillance activities on a regular basis, at least 2-yearly?
5.2	Is prescription appropriateness of antimicrobial choice in accordance with guidelines (e.g. Therapeutic Guidelines: Antibiotic or locally endorsed) audited at least once a year? (e.g. To Dip or Not to Dip audit for UTI prescribing appropriateness)
5.3	Is prescription appropriateness of antimicrobial duration in accordance with guidelines (e.g. Therapeutic Guidelines: Antibiotic or locally endorsed) audited at least once a year? (e.g. To Dip or Not to Dip audit for UTI prescribing)
5.4	Is adherence to documentation of course length or review date recorded at time of prescribing audited least once a year? (e.g. To Dip or Not to Dip audit for UTI prescribing)
5.5	Is usage of key antimicrobial classes (e.g. systemic antibiotics, topical antifungals) and specific antimicrobials (e.g. cefalexin, amoxicillin- clavulanate, ciprofloxacin) monitored?
5.6	Is there a process to review imprest medications, including antimicrobials, to ensure quality of stock (e.g. medications stocked, in date, storage), supply, and use?

6	Reporting and feedback
6.1	Does the committee with AMS oversight develop action plans (e.g. Plan for Continuous Improvement) to issues raised by monitoring of AMS activities (e.g. audit or surveillance results)?
6.2	Are the audit results in section 5 shared with relevant prescribers (e.g. TDONTD audit results on prescribing appropriateness for UTI treatment and prophylaxis, Aged Care NAPS)?
6.3	Are the audit results in section 5 shared with clinical staff? (e.g. TDONTD audit results on prescribing appropriateness for UTI treatment and prophylaxis, Aged Care NAPS)?
6.4	Is infection surveillance performed for common infections (e.g. UTI, skin or soft tissue infections, respiratory infections) or serious infections (e.g. sepsis) in the service? Is the data from infection surveillance fed back to the committee with AMS oversight to monitor rates of antimicrobial use, and infection rates for specific infections?
6.5	Are incident reports through the Incident Management System, regarding infection sentinel events (e.g. preventable death, serious harm) and antimicrobials (e.g. antimicrobial misuse, overuse or underuse) fed

7	Consumers
7.1	Does your service have a written policy informing consumers on aspects of AMS relevant or of interest to them? (e.g. informing consumers on results of surveillance and audits, updates on AMS and quality improvement activities, appropriateness of antimicrobial usage, where to source reliable information on antimicrobials such as Aged Care Quality and Safety Commission resources such as "Do you need Antibiotics"?) (e.g. delivery of information via resident communications, resident handbooks, resident agreements)
7.2	Does your antimicrobial policy include consumer information on antimicrobials on antimicrobial initiation or review, in a format that is suitable to allow for informed decision-making?
7.3	Are consumers or their substitute decision-makers informed that they have been prescribed a medication, including an antimicrobial and the reason why it is considered necessary? Are they informed regarding other treatments and care recommended?
7.4	Are consumers or their substitute decision-makers informed of the risks and side effects associated with medication, including antimicrobials? Are they involved in the decision-making?

ACQSC's AMS resources



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- Defining quality care
- Finding quality care
- Your rights
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  - **Medication: it's your choice**
  - Food & nutrition
- Safety in care
- NDIS & younger people
- Consumer advisory bodies
- Resources for older Australians

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Medication: it's your choice

Medication can improve your quality of life. It can keep you safe and help you to live longer.

Some medicines can have side effects or not work as well as we'd like them to.

It's your right to get thorough information about your medication. And it's up to you if you want to choose a different treatment.

To learn more, explore Medication – it's your choice on the Older Persons Advocacy Network (OPAN). We developed this information suite with OPAN.

You can browse:

- brochures
- booklets
- videos.

Translations are available.

Antimicrobial stewardship

We're working to reduce the unnecessary use of antibiotics in aged care.

Antibiotics are powerful drugs. They can speed up your recovery or save your life if you have a serious infection. But you should only use them when you need to.

When we take antibiotics often, the bacteria in our bodies can become resistant to them. This can lead to antibiotics becoming less effective against some infections.

Antimicrobial stewardship is how we use anitmicrobial drugs to stop resistance building

To Dip or Not to Dip in Australian residential aged care services: key outcomes

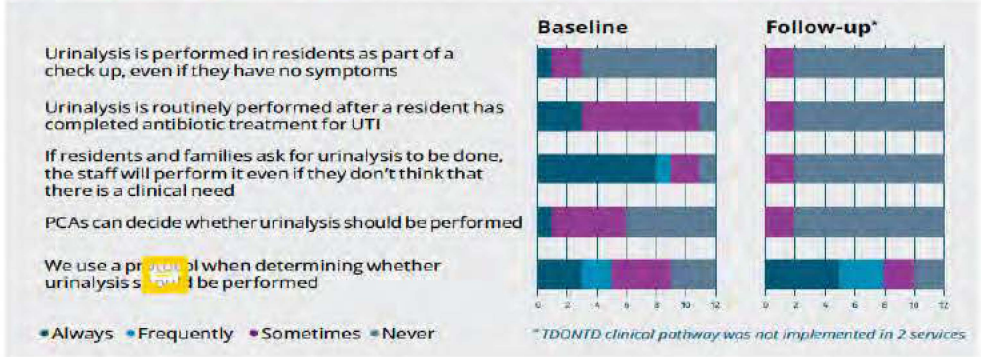
- 12 services
  - 8 Queensland
  - 4 Victoria
- 1,074 residents
- Project from Nov 2021 – Jul 2023

Implementation of a quality improvement activity to reduce low value urine dipstick testing in residential aged care by:
- case-based education to nurses and personal carers
- use of a clinical pathway to identify suspected UTI

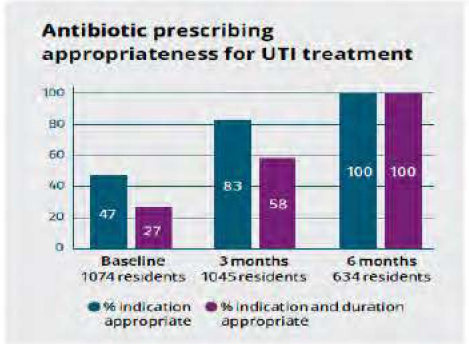
"Before we always had to do dipstick testing after residents completed antibiotic courses for UTI. Now we have been told it is OK not to do it. It has changed our staff thought processes. Instead of dipstick and antibiotics, we are doing more promoting hygiene, toileting regularly, changing pads regularly, encouraging fluids." *(Nurse)*

Findings

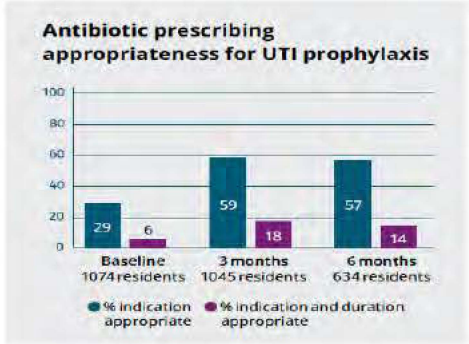
Survey of dipstick practice at baseline and 3 to 6 months



Antibiotic audits



Prescribing for these indications was considered inappropriate: ASB, charted prn, urinary tract indication uncertain and no signs or symptoms at antibiotic commencement. Accepted prescribing durations for cystitis were up to 7 days, for pyelonephritis up to 14 days.



Prescribing for ASB or where indication was unknown or not documented was considered inappropriate. Prescribing durations over 180 days were considered inappropriate.

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Engage
Empower
Safeguard

Clinical pathway for older people in aged care homes: Suspected Urinary Tract Infections (UTI)

Without Catheter

Nurse/Carer: Complete resident details, assessment and management sections.
File in resident notes. **DO NOT PERFORM AN INITIAL URINE DIPSTICK**

Resident name			**Staff name starting form**		
Date of birth	/ /	**Gender** M ○ F ○	**Date** / /	**Time**	

Observations	Pulse		Blood pressure	/	Respiratory rate		Temperature

Assessment — PCA and/or RN

PCA/Nurse to complete		**Nurse to complete**	
NEW or WORSE problem with no other reason found in resident without catheter ☑		**Interpretation in resident without catheter**	**Final interpretation** ☑
Category A			**UTI possible.**
Dysuria, pain or burning on passing urine		If **Category A** ticked: **UTI possible**, for UTI investigation and management.	
Category B		**Category B** — If **both** ticked: **UTI possible**, for UTI investigation and management.	
Fever (≥38°or >1.5° above usual temperature) NB paracetamol formulations e.g. Panadol Osteo™ may mask fever		If **one** of **Category B** and **one** or more of **Category C** ticked: **UTI possible**, for UTI investigation and management.	**Consider other causes as well as UTI.** **Do not perform urine Dipstick.**
Confusion, agitation		If **one** of **Category B** ticked: Consider other causes as well as UTI and discuss with GP. **Do not perform urine Dipstick** (unless specific GP request). If UTI considered possible, for further UTI investigation and management.	
Category C		If **Category C only** ticked: **Consider other causes as well as UTI.** **Do not perform urine Dipstick.** If concern contact GP as usual and monitor resident for changes.	**UTI unlikely.** **Do not perform urine Dipstick.** Consider other causes of symptoms. If concern contact GP as usual and monitor resident for changes.
Frequency on passing urine		If **Category D** ticked: **UTI unlikely.** **Do not perform urine Dipstick.** Consider other causes of symptoms. If concern contact GP as usual and monitor resident for changes.	
Urgency on passing urine			
Urinary incontinence			
Flank, loin, kidney pain or tenderness			
Low abdominal pain			
Visible blood in urine			
Category D			
No signs or symptoms			

Actions — RN to Update

☑	**Action — update as conducted (tick ☑ if undertaken)**	**Date of action**
	If **UTI possible: send urine culture.** Preferred collection techniques: MSU, clean-catch (e.g., if incontinent). Transport to lab within 2 hours or refrigerate (4-10°C until transported).	/ /
	Dipstick performed? **Do not perform dipstick** unless specific GP request.	/ /
	GP review requested.	/ /
	Assess hydration status and encourage fluid intake if dehydrated.	/ /
	Were antibiotics prescribed? If YES, document prescription (e.g. trimethoprim 300mg orally nocte for 3-days).	/ /
	Urine culture sent: results followed up? Lab results usually available within 72 hours. Nursing staff should follow up and discuss with GP (and resident) culture results, review clinical progress and antibiotic plan.	/ /

Version 2. February 2022

Pathway based on Therapeutic Guidelines: Assessment and treatment of aged care residents with suspected UTI.

To Dip or Not to Dip Audit

RACS ID:		**Date audit:**	/ /		
Resident: Surname		**Audit by (name / designation):**	**(1)**	**(2)**	
Resident: First name		**Antibiotic allergies / adverse effect:**			**or not documented**
DOB	/ /	**If allergy / adverse effect, nature and severity**			**or not documented**
Gender	◯ Male ◯ Female	**Did resident have a urinary catheter at onset of UTI symptoms and signs ?**	◯ Yes ◯ No ◯ Unknown		

Agent	**Dose**	**Route**	**Frequency**	**Start date**	**Stop or review date? Indicate which is documented**		**What is the stop or review date?**	**Condition being treated: Site involved**	**For urinary tract sites, more details**	**For urinary tract sites, Indication: Treatment or Prophylaxis**	**For 3 and 6-month audits only. Has resident received this antibiotic continuously since previous audit?**
Free text	*Free text*	*o / im / IV*	*Daily / BD / TDS / QID*	*Date*	☑ *Stop*	☑ *Review*	*Date*	*See options*	*See options*	*Treatment or Prophylaxis*	*Y / N / Not known / Not applicable (Baseline audit)*
					◯	◯				◯ Treatment or Prophylaxis	◯ Yes ◯ No ◯ Not known ◯ Not applicable (Baseline audit)
					◯	◯				◯ Treatment or Prophylaxis	◯ Yes ◯ No ◯ Not known ◯ Not applicable (Baseline audit)
					◯	◯				◯ Treatment or Prophylaxis	◯ Yes ◯ No ◯ Not known ◯ Not applicable (Baseline audit)
					◯	◯				◯ Treatment or Prophylaxis	◯ Yes ◯ No ◯ Not known ◯ Not applicable (Baseline audit)

For antimicrobial prescriptions related to urine tract sites ONLY

Agent	**Antibiotic start date**	**Symptoms or signs on start date related to urinary tract**	**GP review: date most recent GP clinical or prescription review related to this condition**	**GP review: outcome of most recent review, more details**	**Was urine culture sent? If yes date sent**	**Acknowledgement of urine culture result by GP or service staff. If yes, date**
Free text	*Free text*	*See options, choose all that apply*	*Date or Not known*	*See options, choose all that apply*	*Y / N / Not known If yes, date*	*Y / N / Not known If yes, date*
					◯ Yes ◯ No ◯ Not known if yes, date	◯ Yes ◯ No ◯ Not known if yes, date
					◯ Yes ◯ No ◯ Not known if yes, date	◯ Yes ◯ No ◯ Not known if yes, date
					◯ Yes ◯ No ◯ Not known if yes, date	◯ Yes ◯ No ◯ Not known if yes, date

TDONTD education sessions delivered by ACQSC pharmacists

- **QR evaluations between May 2022 and April 2023**
- **How useful did you find this session?**
  - **Out of 10, average score was 9.2, with 57% of attendees ranking it as a perfect '10'**
- **What did you learn?**
  - **38% used the word '*dipsticks*' in reply, mostly '*not to dipstick*'**
  - **UTI management was also mentioned, along with rationalising the use of antibiotics and references to antibiotics (13%)**

"How to use clinical pathways not dipsticks" **(RN)**

"That UTIs are not always the answer, and you should ensure the symptoms meet the criteria before unnecessarily giving people antibiotics". **(PCW)**

How will this session change what you do at work?

- **25% said they would rationalise their use of dipsticks.**
- **13% said they would use the clinical pathway more.**

'It changes work practices so clinical assessment paramount before dipping" (RN)

"Policy regarding dipping after antibiotics will hopefully be reviewed" (EN)

AMS and aged care in 2024

- Refresh of existing TDONTD resources
- New resources
  - TDONTD Implementation guide
  - Dashboard tool for TDONTD antibiotic audit (to support RACS to use data on infections, antibiotic use)
- ACQSC TDONTD implementation training sessions
  - Starting in early 2024, if interest
  - Suitable for:
    - Facility nurses and pharmacists interested in implementing TDONTD
    - Sessions conducted virtually

ACSQHC

- IPC guide for aged care

Australian Government
Aged Care Quality and Safety Commission

Thank you.
Questions?

s.22(1)(a)(ii)

Resource List

- **Aged Care Quality and Safety Commission. Guidance and resources for providers to support Aged Care Quality Standards.**

– **https://www.agedcarequality.gov.au/resources/guidance-and-resources-providers-support-aged-care-quality-standards**

- **Australian Commission for Safety and Quality in Health Care. The strengthened Aged Care Quality Standards – Final draft (November 2023)**

- **https://www.health.gov.au/resources/publications/the-strengthened-aged-care-quality-standards-final-draft?language=en**

- **Australian Commission for Safety and Quality in Health Care. Antimicrobial Stewardship in Australian Health Care**

  Chapters 2 (program), 3 (strategies and tools), 4 (Information technology support), 5 (clinician education), 6 (measuring program) performance and evaluation), 7 (involving consumers), 16 (AMS in community and residential age care)

Date:

– **https://www.safetyandquality.gov.au/publications-and-resources/resource-library/antimicrobial-stewardship-australian-health-care**

Resource List

- **Department of Health and Aged Care. Medication management in residential aged care facilities – Guiding Principles**

– https://www.health.gov.au/resources/publications/guiding-principles-for-medication-management-in-residential-aged-care-facilities?language=en

- **Department of Health and Aged Care. User Guide – Role of the Medication Advisory Committee.**

– https://www.health.gov.au/resources/publications/user-guide-role-of-a-medication-advisory-committee?language=en

- **Australian Commission for Safety and Quality in Health Care. Information for clinicians- Antimicrobial Stewardship Clinical Care Standard.**

– https://www.safetyandquality.gov.au/our-work/clinical-care-standards/antimicrobial-stewardship-clinical-care-standard/info-clinicians#quality-statements