POLICY

catholic healthcare

RAC_Antimicrobial Stewardship Policy

Purpose

To provide policy, position and/or procedural information on Antimicrobial Stewardship which includes:

- Catholic Healthcare Limited (CHL) Residential Aged Care (RAC) specific and in line with the Mission, Vision and Values of the organisation
- Consistent with State & Commonwealth legislation & Aged Care Quality Standards
- Representative of contemporary, evidenced- based best practice in Residential Aged Care

CHL RAC Homes will:

- Adopt measures in order to adhere with the Antimicrobial Stewardship Clinical Care Standards and ensure that a Resident (Consumer) with an infection receives optimal treatment.

Applicability / Scope

This policy applies to Residential Care Employees of CHL.

Contents

Definitions 3

1. Antimicrobial Resistance (AMR) 4
2. Procedure 4
3. Clinical Care Standards 5

3.1 A Resident with a life-threatening condition due to a suspected bacterial infection receives prompt Antibiotic treatment without waiting for the results of investigations. 5

3.2 A Resident with a suspected bacterial infection has samples taken for microbiology testing as clinically indicated, preferably before starting Antibiotic treatment. 5

3.3 A Resident with a suspected infection, and/or their Authorised Representative, receives information on their health condition and treatment options in a format and language that they can understand 5

3.4 When a Resident is prescribed Antibiotics, whether empirical or directed, this is done in accordance with the current version of the Therapeutic Guidelines. This is also guided by the Resident's clinical condition and/or the results of microbiology testing. 6

3.5 When a Resident is prescribed Antibiotics, information about when, how and for how long to take them, as well as potential side effects and a review plan, is discussed with the Resident and/or their Authorised Representatives. 6

3.6 When a Resident is prescribed Antibiotics, the reason, drug name, dose, route of administration, intended duration and review plan is documented in the Resident's health record. 6

3.7 A Resident who is treated with a broad-spectrum Antibiotic has the treatment reviewed and, if indicated, switched to treatment with a narrow-spectrum Antibiotic. This is guided by the Resident's clinical condition and the results of microbiology tests. 6

3.8 If investigations are conducted for a suspected bacterial infection, the responsible clinician reviews these results in a timely manner, preferably within 24 hours of results being available. The Antibiotic therapy is adjusted considering the Resident's clinical condition and investigation results. ..6

3.9 If a Resident having surgery requires Prophylactic Antibiotics, or Prophylaxis is prescribed for other indications (e.g. UTI Prophylaxis or Prophylaxis of respiratory infections in advanced respiratory disease), the prescription is made in accordance with the current Therapeutic Guidelines and takes into consideration the Resident's clinical condition.....7

4. CHL Requires.....7

5. Criteria for Infection Reporting in eCase & Documentation 7

5.1 Urinary Tract Infection (includes only symptomatic UTIs): 7

5.2 Respiratory Tract Infection (includes common cold, pharyngitis, influenza-like illness, pneumonia, bronchitis).....8

5.3 Gastrointestinal Tract (GIT) Infection 11

5.4 Skin, Soft Tissue and Mucosal Infections (includes mouth and eye infections) 12

RAC_Antimicrobial Stewardship Policy

Definitions

Antimicrobials	Medications used to treat an infection; including bacterial, fungal, and viral.
Antibiotic	Medication specifically aimed at treating a bacterial infection.
Infection Criteria in Residential Care Homes	1. Fever • Single oral temperature 37.8°C OR • Repeated oral temperatures 37.2°C or rectal temperatures 37.5°C OR • Single temperature 1.1°C over baseline for the individual from any site (oral, tympanic, axillary) 2. Leucocytosis • Neutrophilia (14,000 leukocytes/mm3) OR • Left shift (6% bands or ≥1,500 bands/mm3) 3. Acute change in mental status from baseline (all criteria must be present) • Acute onset • Fluctuating course • Inattention AND • Either disorganised thinking or altered level of consciousness 4. Acute functional decline A new 3-point increase in total activities of daily living (ADL) score (range, 0– 28) from baseline, based on the following 7 ADL items, each scored from 0 (independent) to 4 (total dependence) • Bed mobility • Transfer • Locomotion within RAC Home • Dressing • Toilet use • Personal hygiene • Eating
Optimal Treatment for a Resident means using:	• the *right Antibiotic* to treat their condition • the *right dose* • by the *right route* • at the *right time* and • for the *right duration* based on accurate assessment and timely review.

RAC_Antimicrobial Stewardship Policy

1. Antimicrobial Resistance (AMR)

Antimicrobial resistance (AMR) is recognised as a global health priority, to combat AMR, clinical care standards have been devised to facilitate the slowing down of the resistance.

Residential aged care facilities are recognised nationally and internationally as an important community setting for taking action in relation to antimicrobial resistance and antimicrobial use, because of the significant burden of infection and colonisation with resistant organisms.

CHL will adopt measures to minimise AMR via:

- Increasing awareness within the Home of AMR.
- Administering Antibiotics appropriately.
- Adopting care strategies to minimise the need for Antibiotics.

2. Procedure

- Processes are in place to promote the appropriate use and review of Antibiotics to optimise a Resident's health outcomes, lessen the risk of adverse effects and reduce the risk of increasing emergence of Antibiotic resistance. This includes following the Clinical Care Standards detailed below with support from the prescribing practitioner.
- Internal review processes are in place to regularly assess antimicrobial use in accordance with achieving organisational goals for management. This may include:
    - Monthly Audit of Antimicrobial Use as per Scheduled Audits
    - Review Antibiotic usage report from supply pharmacists
    - Review audit and report results in MAC meeting
    - Consider participation in the Aged Care National Antimicrobial Prescribing Survey (ACNAPS)- annual. https://www.naps.org.au/Default.aspx
- CHL Clinical Governance Committee will review and monitor antimicrobial stewardship.

3. Clinical Care Standards

3.1 A Resident with a life-threatening condition due to a suspected bacterial infection receives prompt Antibiotic treatment without waiting for the results of investigations.

Considerations

- The Home's Medication Advisory Committee determines which emergency stock Antibiotics are to be available so that they can be commenced immediately after they are ordered by an Authorised prescriber.
- Where state/territory legislation restricts the range of Antibiotics allowed to be held as emergency stock, the Medical Practitioner or other Authorised Prescriber is advised of the Antibiotics available as emergency stock on-site and the Home's local procedures for urgent out-of-hours supply from the contracted pharmacy. Refer to *RAC_Medication Manual_Section 5 Ordering Receipt Storage and Disposal*

3.2 A Resident with a suspected bacterial infection has samples taken for microbiology testing as clinically indicated, preferably before starting Antibiotic treatment.

Considerations

- This is at the direction of and as clinically indicated by the treating Medical Practitioner or other Authorised Prescriber.
- Staff follow the appropriate method for obtaining the sample correctly. This includes minimising the risk of contamination, labelling of the sample correctly, and ensuring appropriate storage in the specimen refrigerator prior to collection.
- Timely transfer to pathology of the specimen is facilitated by the home.

3.3 A Resident with a suspected infection, and/or their Authorised Representative, receives information on their health condition and treatment options in a format and language that they can understand.

Considerations

- This allows the individual Resident and/or their Authorised Representative, to exercise choice which may include to decline recommended treatment. This decision should be documented in eCase Progress Notes.
- Consider ensuring support is in place for Prescribing Practitioners to provide Residents and/or their Authorised Representatives with information and advice on antimicrobial treatment options.

3.4 When a Resident is prescribed Antibiotics, whether empirical or directed, this is done in accordance with the current version of the Therapeutic Guidelines. This is also guided by the Resident's clinical condition and/or the results of microbiology testing.

Considerations

- Consider providing access for Authorised Prescribers to the Therapeutic Guidelines (TG) at the Home to facilitate prescribing according to current guidelines. This is available online through eTG.

3.5 When a Resident is prescribed Antibiotics, information about when, how and for how long to take them, as well as potential side effects and a review plan, is discussed with the Resident and/or their Authorised Representatives.

3.6 When a Resident is prescribed Antibiotics, the reason, drug name, dose, route of administration, intended duration and review plan is documented in the Resident's health record.

Considerations

- The Authorised Prescriber should specify the duration of treatment in days or doses on the medication chart at the time of prescribing. There should be review during the course and at the completion of therapy
- The pharmacist who supplies an Antibiotic for emergency stock use or on a prescription for a Resident, includes instructions about how and when to take the Antibiotic to optimise its efficacy.

3.7 A Resident who is treated with a broad-spectrum Antibiotic has the treatment reviewed and, if indicated, switched to treatment with a narrow-spectrum Antibiotic. This is guided by the Resident's clinical condition and the results of microbiology tests.

3.8 If investigations are conducted for a suspected bacterial infection, the responsible clinician reviews these results in a timely manner, preferably within 24 hours of results being available. The Antibiotic therapy is adjusted considering the Resident's clinical condition and investigation results.

Considerations

- Where the Home receives pathology results, timely communication of receipt of these will be delivered to the prescribing practitioner for informed decision making.

3.9 If a Resident having surgery requires Prophylactic Antibiotics, or Prophylaxis is prescribed for other indications (e.g. UTI Prophylaxis or Prophylaxis of respiratory infections in advanced respiratory disease), the prescription is made in accordance with the current Therapeutic Guidelines and takes into consideration the Resident's clinical condition.

4. CHL Requires

- All infections to be recorded into *eCase Resident Infection Register*
- Recognise, Report & Management cases of outbreaks, refer to RAC_Guideline_Outbreak Management_Gasteroenteritis; RAC_Guideline_Outbreak Management_Influenza; and RAC Infection Prevention and Control Manual
- Infection Register data to be reviewed at *the Management & Quality Meeting and MAC meeting*

5. Criteria for Infection Reporting in eCase & Documentation

5.1 Urinary Tract Infection (includes only symptomatic UTIs):	eCase Documentation
Resident ***Does Not*** have an IDC/SPC. **Both criteria 1 and 2** must be present: 1. **At least 1** of the following sign or symptom sub-criteria: • Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate • Fever or leucocytosis and **at least 1** of the following localising urinary tract sub-criteria: o Acute costovertebral angle pain or tenderness o Suprapubic pain o Gross haematuria o New or marked increase in incontinence o New or marked increase in urgency o New or marked increase in frequency • In the absence of fever or leucocytosis, then **2 or more** of the following localising urinary tract sub-criteria: o Suprapubic pain o Gross haematuria o New or marked increase in incontinence o New or marked increase in urgency o New or marked increase in frequency	1. Progress Notes (Select Infection – UTI) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Toileting** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

5.1 Urinary Tract Infection (includes only symptomatic UTIs):	eCase Documentation
2. **One** of the following microbiological sub-criteria: • At least 105 cfu/mL of no more than 2 species of microorganisms in a voided urine sample (cfu = colony forming units) • At least 102 cfu/mL of any number of organisms in a specimen collected by in-and-out catheter **NOTE:** UTI should be diagnosed when there are localising genitourinary signs and symptoms and a positive urine culture result. A diagnosis of UTI can be made without localising symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection.	
Resident ***Does Have*** an IDC/SPC. **Both criteria 1 and 2** must be present: 1. **At least 1** of the following sign or symptom sub-criteria: • Fever, rigours, or new-onset hypotension, with no alternate site of infection • Either acute change in mental status or acute functional decline, with no alternate diagnosis and leucocytosis • New-onset suprapubic pain or costovertebral angle pain or tenderness • Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate 2. Urinary catheter specimen culture with at least 105 cfu/mL of any organism(s) **NOTE:** Recent catheter trauma, catheter obstruction, or new onset haematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis.	1. Progress Notes (Select Infection – UTI) 2. Infection Register– **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Catheter** Assessment & Care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

5.2 Respiratory Tract Infection (includes common cold, pharyngitis, influenza-like illness, pneumonia, bronchitis)	eCase Documentation
A) Common Cold Syndrome or Pharyngitis (**at least 2 criteria** must be present) 1. Runny nose or sneezing 2. Stuffy nose (i.e., congestion) 3. Sore throat or hoarseness or difficulty in swallowing 4. Dry cough 5. Swollen or tender glands in the neck (cervical lymphadenopathy) **NOTE:** Fever may or may not be present. Symptoms must be new and not attributable to allergies.	1. Progress Notes (Select Infection – Respiratory) 2. Infection Register– **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Medication** Assessment & Care Plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

5.2 Respiratory Tract Infection (includes common cold, pharyngitis, influenza-like illness, pneumonia, bronchitis)	eCase Documentation
B) Case Definition of Influenza-Like Illness (ILI) for Residential Care Homes The following case definition should be used for ILI in staff and Residents of Residential Care Homes: **Sudden onset of symptoms AND** at least **one** of the following three respiratory symptoms: 1. Cough (new or worsening) 2. Sore throat 3. Shortness of breath **AND** at least **one** of the following four systemic symptoms: 1. Fever or feverishness 2. Malaise 3. Headache 4. Myalgia **Note:** When a person meets the case definition for influenza-like illness, they are counted as a 'case of ILI', but a laboratory test is required to confirm (or reject) a diagnosis of influenza. It is important to arrange laboratory testing for influenza as other respiratory pathogens can be tested for at the same time.	1. Progress Notes (Select Infection – Respiratory) 2. Infection Register– **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Medication** Assessment & Care Plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes
C) Definition of A Confirmed Case of Influenza: A case of ILI with a **positive** laboratory test result for influenza meeting the national influenza (laboratory confirmed) surveillance case definition. This means a laboratory test prescribed in the national surveillance case definition has confirmed the presence of influenza virus in the person with ILI, and changes their status from a 'case of ILI' to a diagnosed 'case of influenza'. **NOTE:** If criteria for influenza-like illness and another upper or lower RTI are met at the same time, only the diagnosis of influenza-like illness should be recorded. Because of increasing uncertainty surrounding the timing of the start of influenza season, the peak of influenza activity, and the length of the season, "seasonality" is no longer a criterion to define influenza-like illness.	1. Progress Notes (Select Infection – Respiratory) 2. Infection Register– **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Medication** Assessment & Care Plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

5.2 Respiratory Tract Infection (includes common cold, pharyngitis, influenza-like illness, pneumonia, bronchitis)	eCase Documentation
D) Pneumonia (all 3 criteria must be present) 1. Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate 2. At least 1 of the following respiratory sub-criteria: • New or increased cough • New or increased sputum production • O2 saturation 94% on room air or a reduction in O2 saturation of 3% from baseline • New or changed lung examination abnormalities • Pleuritic chest pain • Respiratory rate of ≥25 breaths/min 3. At least 1 of the constitutional criteria NOTE: For both pneumonia and lower RTI, the presence of underlying conditions that could mimic the presentation of an RTI (e.g., congestive heart failure or interstitial lung diseases) should be excluded by a review of clinical records and an assessment of presenting symptoms and signs	1. Progress Notes (Select Infection – Respiratory) 2. Infection Register– not to record for Prophylactic antibiotics 3. Recurrent and Chronic Infection – document in Medication Assessment & Care Plan 4. Communicable infections – document in Risk Assessment & Care Plan 5. eCase Alerts AND Notes
E) Lower Respiratory Tract (bronchitis or tracheobronchitis; (all 3 criteria must be present) 1. Chest radiograph not performed or negative results for pneumonia or new infiltrate 2. At least 2 of the bulleted respiratory sub-criteria listed in section D above 3. At least 1 of the constitutional criteria	1. Progress Notes (Select Infection – Respiratory) 2. Infection Register– not to record for Prophylactic antibiotics 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in Medication Assessment & Care Plan 4. Communicable infections – document in Risk Assessment & Care Plan 5. eCase Alerts AND Notes

RAC_Antimicrobial Stewardship Policy

5.3 Gastrointestinal Tract (GIT) Infection	eCase Documentation
A) Gastroenteritis (at least **1** of the following criteria must be present) 1. Diarrhoea: **3 or more liquid or watery stools** above what is normal for the resident **within a 24-hour** period 2. Vomiting: **2 or more episodes** in a **24-hour period** 3. Both of the following sign or symptom sub-criteria: • A stool specimen testing **positive** for a pathogen (e.g., Salmonella, Shigella, Escherichia coli O157: H7, Campylobacter species, rotavirus) • At least **1** of the following GI sub-criteria: o Nausea o Vomiting o Abdominal pain or tenderness o Diarrhoea **NOTE:** Care must be taken to exclude non-infectious causes of symptoms. For instance, new medications may cause diarrhoea, nausea, or vomiting; initiation of new enteral feeding may be associated with diarrhoea, and nausea or vomiting may be associated with gallbladder disease.	1. Progress Notes (Select Infection – Gastrointestinal) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Toileting** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes
B) Norovirus gastroenteritis (both criteria 1 and 2 must be present) 1. At least **1** of the following GI sub-criteria • Diarrhoea: **3 or more liquid or watery stools** above what is normal for the resident **within a 24-hour period** • Vomiting: **2 or more episodes** of in a **24-hour period** 2. A stool specimen for which norovirus is **positively** detected by electron microscopy, enzyme immunoassay, or molecular diagnostic testing such as polymerase chain reaction (PCR) **NOTE:** In the absence of laboratory confirmation, an outbreak (2 or more cases occurring in a Residential Care Home) of acute gastroenteritis due to norovirus infection may be assumed to be present if all the following criteria are present ('Kaplan Criteria'): 1. vomiting in more than half of affected persons 2. a mean (or median) incubation period of 24–48 hours 3. a mean (or median) duration of illness of 12–60 hours 4. and no bacterial pathogen is identified in a stool culture.	1. Progress Notes (Select Infection – Gastrointestinal) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Toileting** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

5.3 Gastrointestinal Tract (GIT) Infection	eCase Documentation
C) *Clostridium difficile* infection (both criteria 1 and 2 must be present) 1. One of the following GI sub-criteria • Diarrhoea: 3 or more liquid or watery stools above what is normal for the resident within a 24-hour period. • Presence of toxic megacolon (abnormal dilatation of the large bowel, documented radiologically). 2. One of the following diagnostic sub-criteria • A stool sample yields a positive laboratory test result for C. difficile toxin A or B, or a toxin-producing C. difficile organism is identified from a stool sample culture or by a molecular diagnostic test such as PCR. • Pseudomembranous colitis is identified during endoscopic examination or surgery or in the histopathologic examination of a biopsy specimen. NOTE: A 'primary episode' of C. difficile infection is defined as one that has occurred without any previous history of C. difficile infection or that has occurred 18 weeks after the onset of a previous episode of C. difficile infection. A "recurrent episode" of C. difficile infection is defined as an episode of C. difficile infection that occurs 8 weeks or sooner after the onset of a previous episode, provided that the symptoms from the earlier (previous) episode have resolved. Individuals previously infected with C. difficile may continue to remain colonised even after symptoms resolve. In the setting of an outbreak of GI infection, individuals could have positive test results for the presence of C. difficile toxin because of ongoing colonisation and also be coinfected with another pathogen. It is important that other surveillance criteria be used to differentiate infections in this situation.	1. Progress Notes (Select Infection – Gastrointestinal) 2. Infection Register – not to record for Prophylactic antibiotics 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in Toileting assessment & care plan 4. Communicable infections – document in Risk Assessment & Care Plan 5. eCase Alerts AND Notes

5.4 Skin, Soft Tissue and Mucosal Infections (includes mouth and eye infections)	eCase Documentation
A) Cellulitis, soft tissue, or wound infection (at least 1 of the following criteria must be present) 1. Pus present at a wound, skin, or soft tissue site 2. New or increasing presence of at least 4 of the following sign or symptom sub-criteria • Heat at the affected site • Redness at the affected site • Swelling at the affected site • Tenderness or pain at the affected site • Serous drainage at the affected site • One constitutional criterion NOTE: Presence of organisms cultured from the surface (e.g., superficial swab sample) of a wound is not sufficient evidence that the wound is infected.	1. Progress Notes (Select Infection – Skin) 2. Infection Register – not to record for Prophylactic antibiotics 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in Skin assessment & care plan 4. Communicable infections – document in Risk Assessment & Care Plan 5. eCase Alerts AND Notes

5.4 Skin, Soft Tissue and Mucosal Infections (includes mouth and eye infections)	eCase Documentation
For wound infections related to surgical procedures, RAC Homes should use the Australian Commission on Safety and Quality in Healthcare Surgical Site Infection Criteria and report these infections back to the institution where the original surgery was performed. More than 1 resident with streptococcal skin infection from the same serogroup (e.g., A, B, C, G) in a RAC Home may indicate an outbreak.	
B) Scabies (**both criteria 1 and 2 must be present**) 1. A maculopapular and/or itching rash 2. At least **1** of the following scabies sub-criteria • Physician diagnosis • Laboratory confirmation (scraping or biopsy) • Epidemiologic linkage to a case of scabies with laboratory confirmation **NOTE:** An epidemiologic linkage to a case can be considered if there is evidence of geographic proximity in the RAC Home, temporal relationship to the onset of symptoms, or evidence of a common source of exposure (i.e., shared caregiver). Care must be taken to rule out rashes due to skin irritation, allergic reactions, eczema, and other non-infectious skin conditions.	1. Progress Notes (Select Infection – Skin) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Skin** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes
C) Fungal oral or perioral and skin infections 1. Oral candidiasis (**both criteria a and b** must be present) a. Presence of raised white patches on inflamed mucosa or plaques on oral mucosa b. Diagnosis by a medical or dental provider 2. Fungal skin infection (**both criteria a and b** must be present) a. Characteristic rash or lesions b. Either a diagnosis by a medical provider or a laboratory-confirmed fungal pathogen from a scraping or a medical biopsy **NOTE:** Mucocutaneous *Candida* infections are usually due to underlying clinical conditions such as poorly controlled diabetes or severe immunosuppression. Although they are not transmissible infections in the healthcare setting, they can be a marker for increased antibiotic exposure. Dermatophytes have been known to cause occasional infections and rare outbreaks in the RAC Home.	1. Progress Notes - Select a. Infection – Ear, Eye, Mouth **or** b. Infection - Skin 2. Infection Register– **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics document in a. **Personal Hygiene** Assessment & Care Plan **or** b. **Skin** Assessment & Care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

RAC_Antimicrobial Stewardship Policy

5.4 Skin, Soft Tissue and Mucosal Infections (includes mouth and eye infections)	eCase Documentation
D) Herpes virus skin infections 1. Herpes simplex infection (**both criteria a and b** must be present) a. A vesicular rash b. Either physician diagnosis or laboratory confirmation 2. Herpes zoster infection (**both criteria a and b** must be present) a. A vesicular rash b. Either physician diagnosis or laboratory confirmation **NOTE:** Reactivation of herpes simplex (cold sores) or herpes zoster (shingles) is not considered a healthcare-associated infection. Primary herpes virus skin infections are very uncommon in an RAC Home except in paediatric populations, where it should be considered healthcare associated.	1. Progress Notes (Select Infection – Skin) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Skin** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes
E) **Conjunctivitis** (at least **1** of the following criteria must be present) 1. Pus appearing from 1 or both eyes, present for at least 24 hours 2. New or increased conjunctival erythema, with or without itching 3. New or increased conjunctival pain, present for at least 24 hours **NOTE:** Conjunctivitis symptoms ("pink eye") should not be due to allergic reaction or trauma.	1. Progress Notes (Select Infection – Ear, Eye, Mouth) 2. Infection Register – **not to record for Prophylactic antibiotics** 3. Recurrent & Chronic Infection and Prophylactic antibiotics – document in **Personal Hygiene** assessment & care plan 4. Communicable infections – document in **Risk** Assessment & Care Plan 5. eCase Alerts AND Notes

End of Policy

POLICY

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RAC_Antimicrobial Stewardship Policy

Review History

Version Number	Date of Review & Update
Version 2	10 Mar 2021
Version 1	22 Jun 2019

Reference & Related Documents

References	• Australian Commission on Safety and Quality in Health Care. Antimicrobial Stewardship Clinical Care Standard. Sydney: ACSQHC, 2014. • Antimicrobial Stewardship Meditrax 2019, Available from: https://www.naps.org.au/Default.aspx
Related Policies, Procedures & Guidelines	• Bug Control e-Manual • RAC_Guideline_Outbreak Management_Gastroenteritis • RAC_Guideline_Outbreak Management_Influenza • RAC_Influenza Vaccination Management Policy - Residents • RAC_Procedure_Maintaining an Outbreak Management Kit (OMK) • RAC Medication Manual
Related Documents & Forms	Documents: • eCase Assessment, Care Planning, Chart, Progress Note & Registers • RAC Auditing Document
Aged Care Quality Standards	This guideline may impact on the following Aged Care Quality Standards: • Standard 1 – Consumer dignity and choice • Standard 2 – Ongoing assessment and planning with consumers • Standard 3 – Personal care and clinical care • Standard 4 – Services and supports for daily living • Standard 5 – Organisation's service environment • Standard 6 – Feedback and complaints • Standard 7 – Human resources • Standard 8 – Organisational governance
Legislation	This guideline is guided by the following legislation: • Aged Care Act 1997 • Quality of Care Principles 2014 • User Rights Amendment (Charter of Aged Care Rights) Principles 2019

Key words for search

Infection, Antimicrobials, Antibiotic, Antimicrobial Stewardship