Acknowledgements: contributing experts

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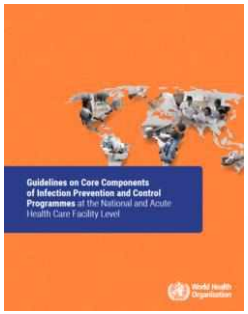
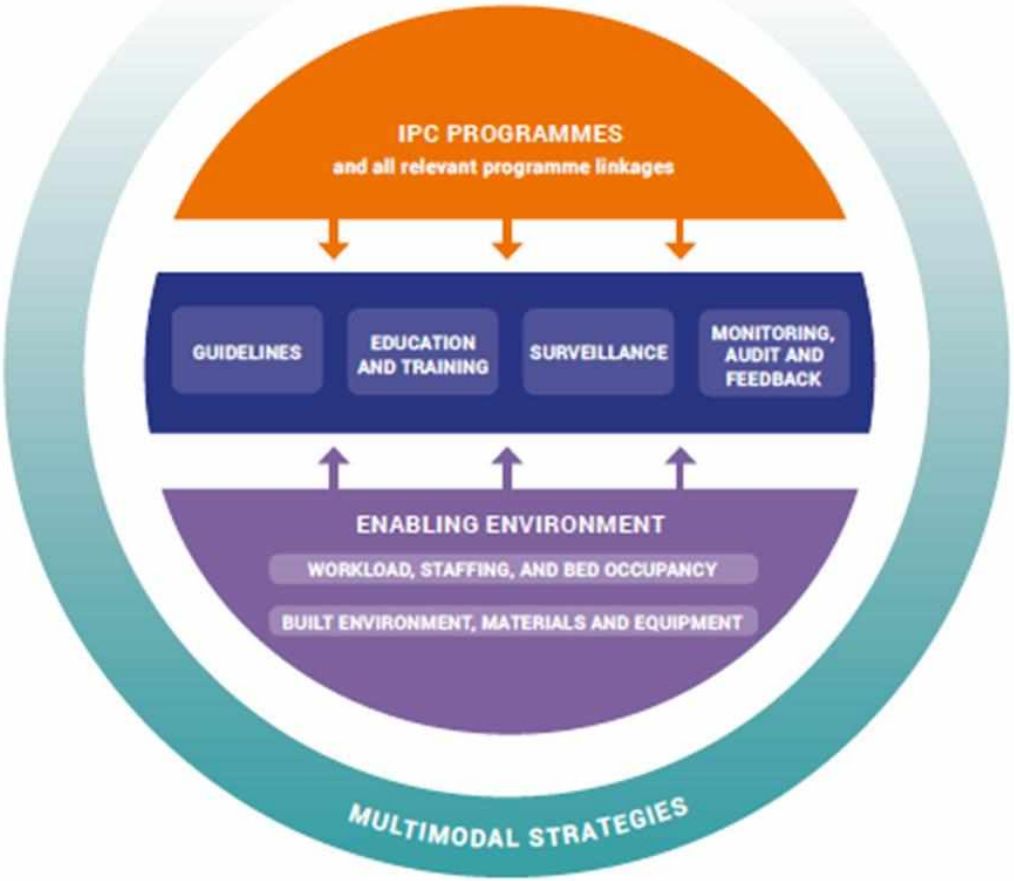
The importance of IPC

- Preventing harm to patients, health workers and visitors due to infection in health care facilities is fundamental to achieve **quality care, patient safety, health security** and the reduction of health care-associated infections (HAIs) and antimicrobial resistance (AMR).
- Similarly, preventing and reducing the transmission of infectious diseases that pose **global threats**, (e.g., pandemic influenza, Ebola virus disease and other viral haemorrhagic fevers), is paramount.
- Clean, safe care is a **patient right** and should also be the duty and pride of all those working in the health care sector.



WHO core components for effective IPC programmes

World Health Organization



- 8 Core components
  - *8 Facility level*
  - *6 National level*
- 11 evidence*-based recommendations
- 3 good practice statements

* Evidence from LMICs:
- 7 high-quality studies
- 22 lower quality

R = recommendation; GPS: good practice statement

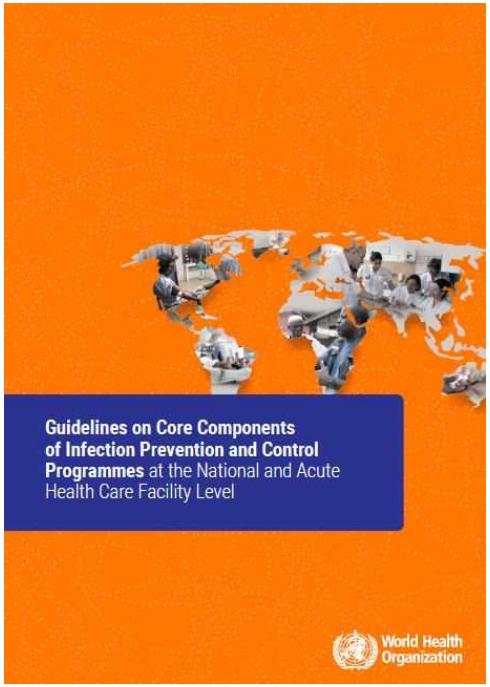
WHO 2019 Global Survey on IPC at the facility level

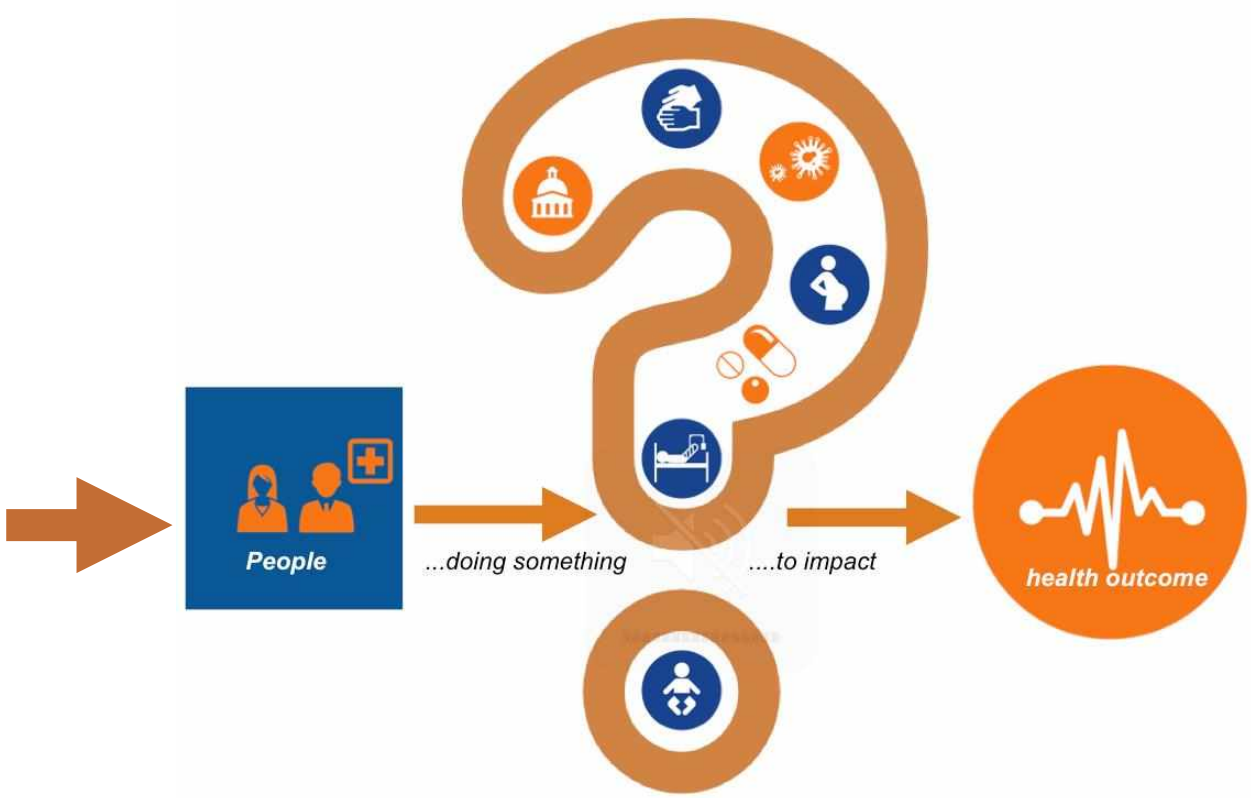
Box 8. IPCAF scoring interpretation

Score		Interpretation
0-200	Inadequate	IPC core components' implementation is deficient. Significant improvement is required.
201-400	Basic	Some aspects of the IPC core components are in place, but not sufficiently implemented. Further improvement is required.
401-600	Intermediate	Most aspects of IPC core components are appropriately implemented. Continue to improve the scope and quality of implementation and focus on the development of long-term plans to sustain and further promote the existing IPC programme.
601-800	Advanced	The IPC core components are fully implemented according to the WHO recommendations and appropriate to the needs of your facility.

https://www.who.int/infection-prevention/campaigns/ipc-global-survey-2019/en/

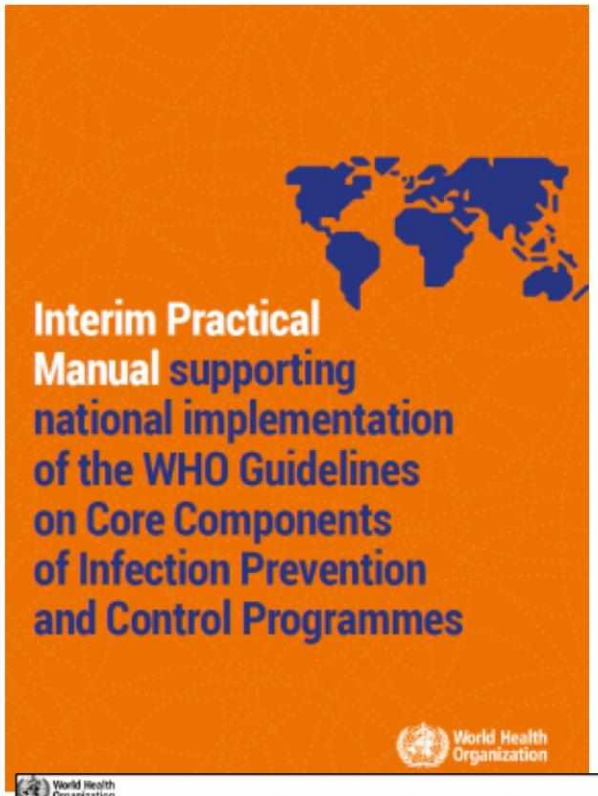
Translating guidelines into action

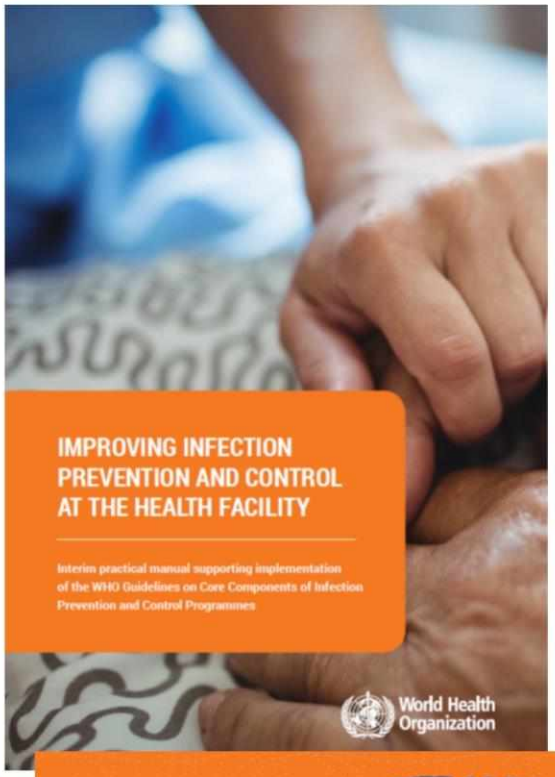


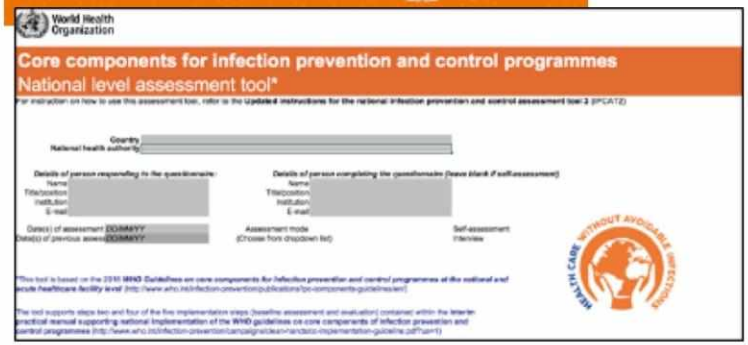


Implementation resources and assessment tools for national and facility level

World Health Organization



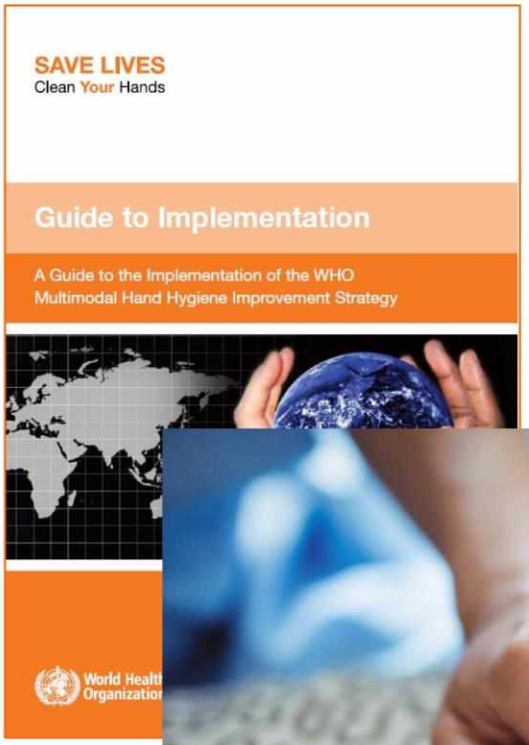


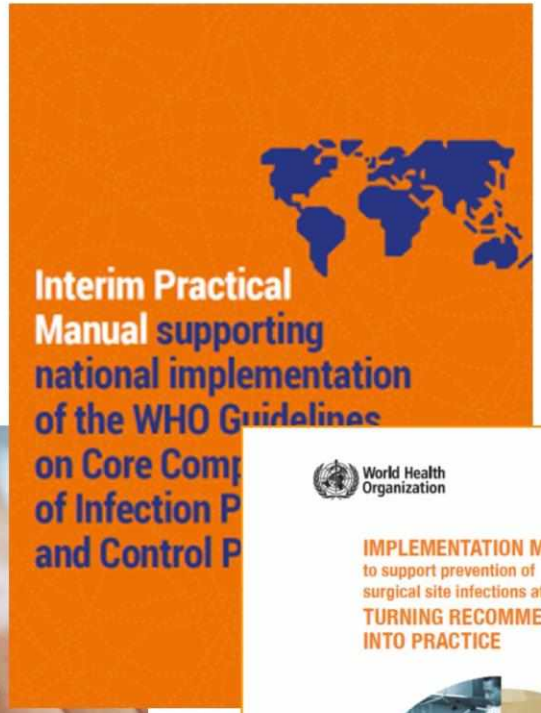


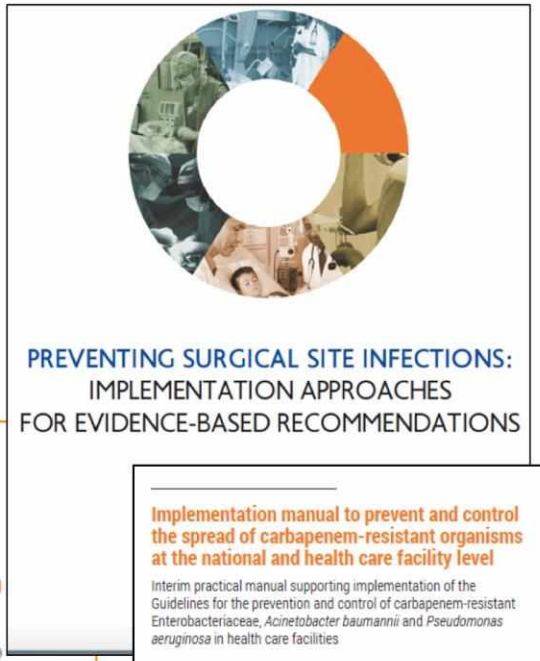
http://www.who.int/infection-prevention/tools/core-components/en/

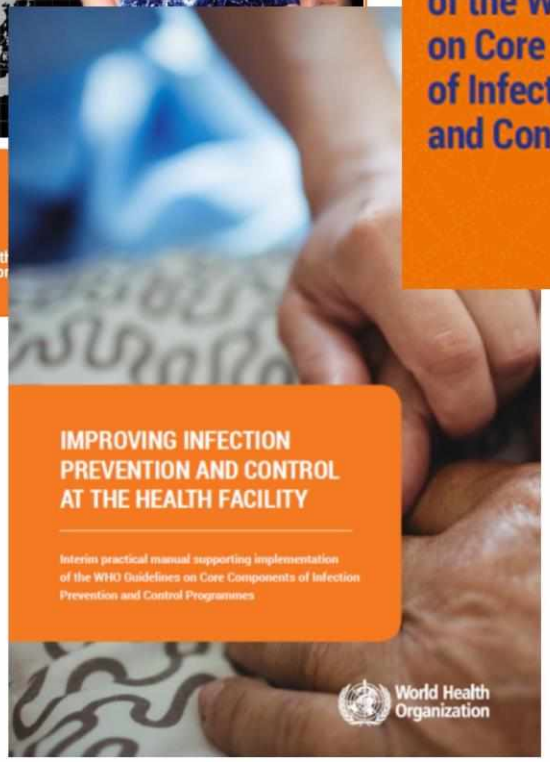
Implementation manuals

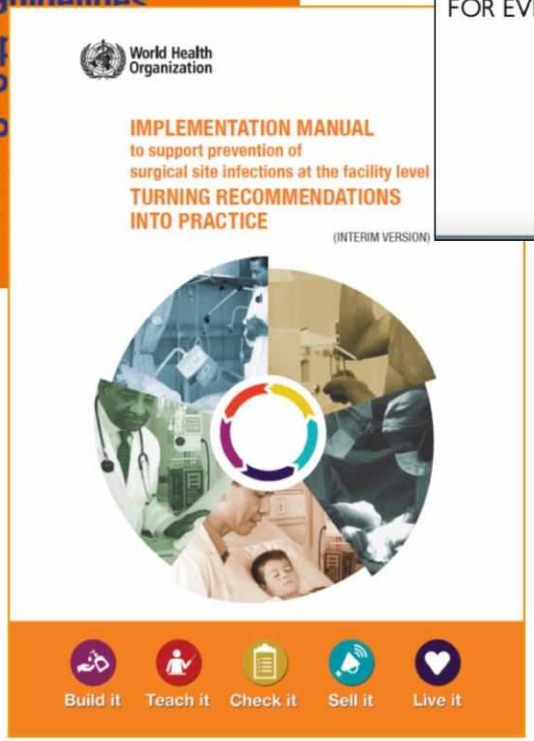
World Health Organization











Ultimate goal

- For all countries: to achieve implementation/improvement of the **full** requirements of **all** core components to effectively reduce HAIs and AMR.
- The 8 core components of IPC are the 'wheels of the cart' that will ensure patients a safe journey while in a health care facility.
- Especially for countries where IPC is limited or does not exist, it is critical to start this journey by ensuring that at least ***minimum requirements for IPC*** are in place.

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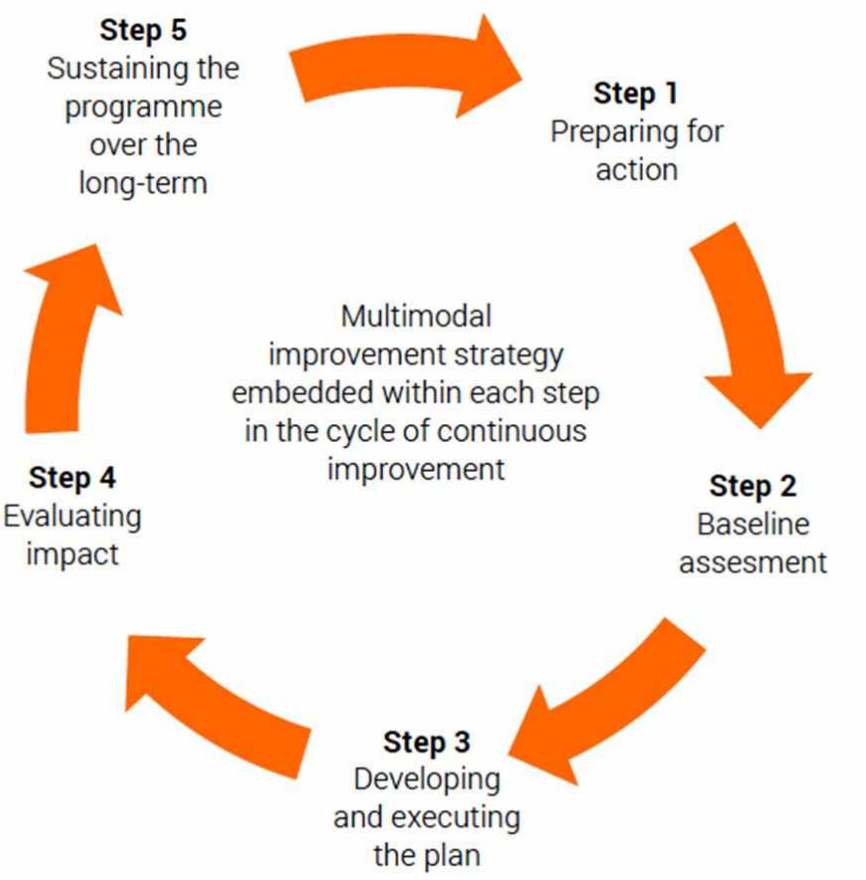
So, what are the *minimum requirements*?

Thus, the minimum requirements represent the starting point for undertaking the journey to build strong and effective IPC programmes at the national and facility level (Fig. 2) and SHOULD be in place for all countries and healthcare facilities to support further progress towards full implementation of all core components.

The *minimum requirements* are defined as:

IPC standards that should be in place at the national and facility level to provide minimum protection and safety to patients, HCWs and visitors, based on the WHO core components for IPC programmes.

A stepwise approach



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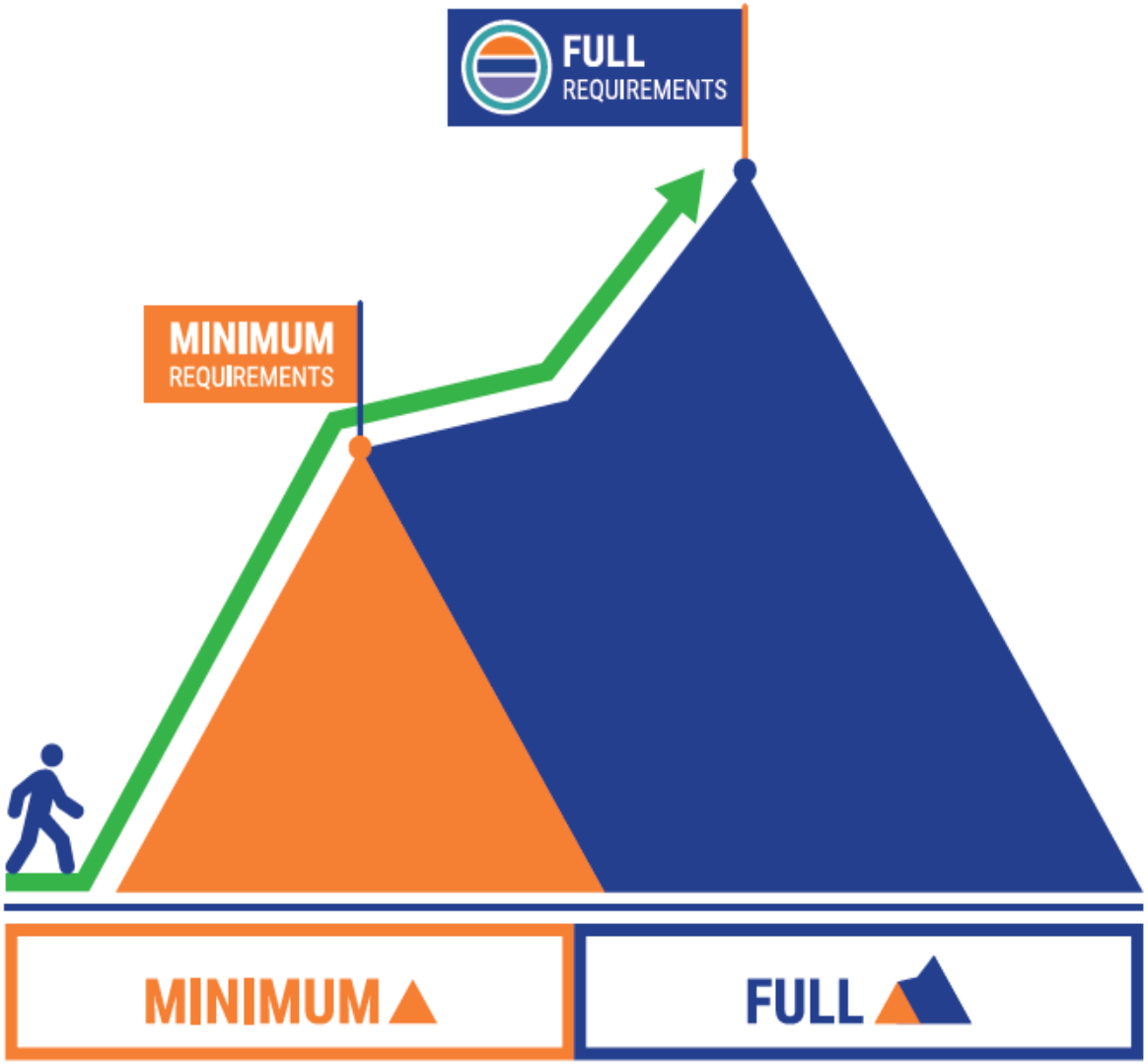

New, launched on 19 November 2019!

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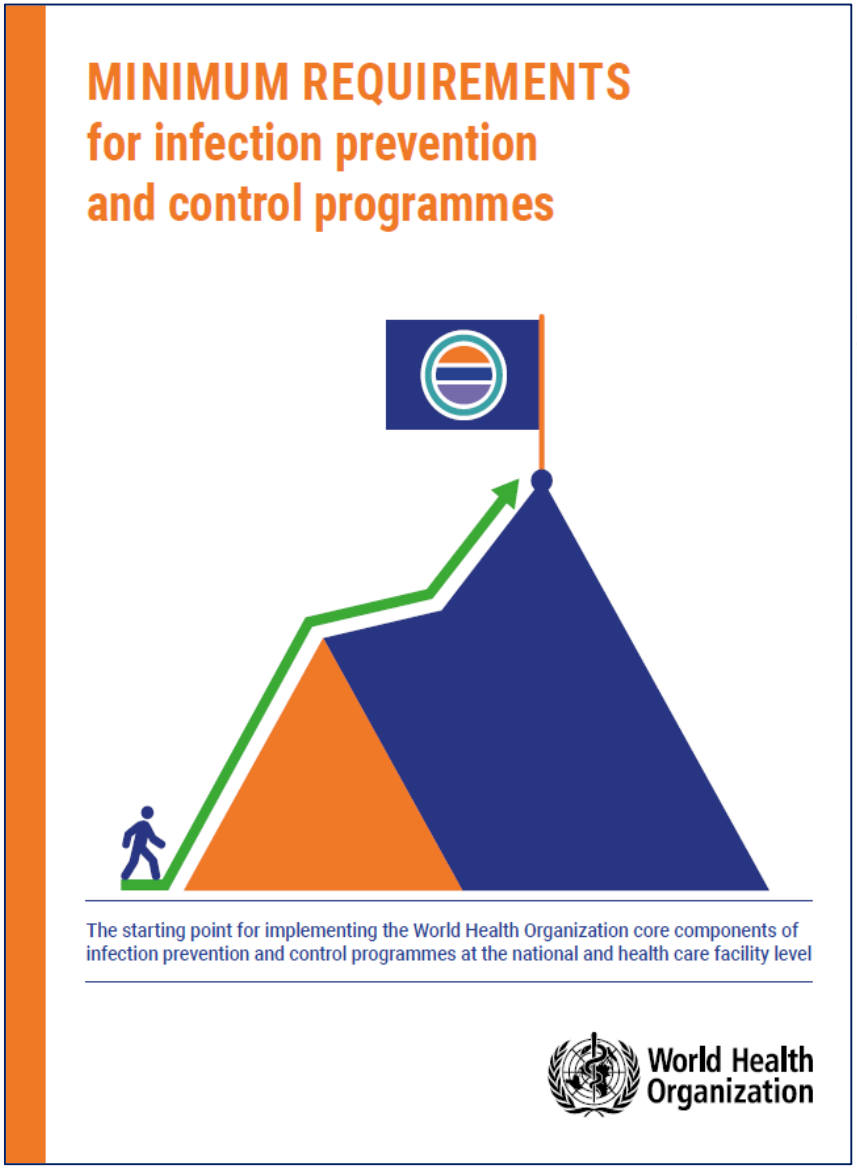

Anyone interested in understanding and implementing the *minimum requirements* should read the WHO Guidelines on core components of IPC programmes *(1)* and the manuals supporting their implementation at the national and facility levels *(2, 3)*.

The main target audience of this document are IPC and AMR focal points/leads, policy makers, senior managers and other professionals with the mandate of or interested in developing or strengthening IPC programmes at the national, sub-national and facility level.

https://www.who.int/infection-prevention/publications/core-components/en/

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BOX 1 STRUCTURE OF THE MINIMUM REQUIREMENTS (PART 3)

WHAT	WHO	HOW	WHY	FULL REQUIREMENTS
Minimum requirements	Is responsible for action	To measure progress	Rationale and additional details on the *minimum requirements*	Full core component requirements
Text of the *minimum requirements* for each IPC core component identified by expert consensus according to national and health care facility level and based on existing IPC and WASH recommendations and standards.	Identification of those who have the mandate to ensure that the *minimum requirements* are put in place and sustained or can play a role.	Indicators to be used to track implementation and progress for each *minimum requirement* are available from different WHO monitoring tools.	Explanations about the reasons for selecting the agreed *minimum requirements* (rationale) and additional details explaining their content and importance.	Comprehensive list of the actions and requirements* to achieve full implementation of each IPC core component. Note that these exist only for acute care hospitals because the WHO recommendations on IPC core components apply mainly to these facilities and not specifically to primary care facilities.

* Note that in some cases, there are no major differences compared to the *minimum requirements*.

Classification of health care facilities used in the document

Primary health care facilities: Facilities that provide outpatient services, family planning, antenatal care, maternal, newborn and child health services (including delivery), for example, health centres, health posts and small district hospitals.
Source: WHO. Water and sanitation for health facility improvement tool (WASH FIT). 2017 (https://apps.who.int/iris/bitstream/handle/10665/254910/9789241511698-eng.pdf;jsessionid=0A60107AA8F5A27C5FD16B0823D3F4FA?sequence=1)

Secondary health care facilities included:

- **Primary-level hospital:** Few specialties—mainly internal medicine, obstetrics and gynaecology, paediatrics and general surgery, or just general practice; limited laboratory services available for general, but not specialized, pathological analysis.
- **Secondary-level hospital:** Highly differentiated by its function with 5 to 10 clinical specialties; size ranges from 200 to 800 beds; often referred to as a *provincial or district hospital.*

Tertiary health care facilities: Highly specialized staff and technical equipment, for example, cardiology, intensive care unit and specialized imaging units; clinical services highly differentiated by function; may have teaching activities; size ranges from 300 to 1500 beds; often referred to as a *teaching or university or regional hospital.*
Source: WHO. Disease control priorities in developing countries. 2008 (https://www.who.int/management/facility/ReferralDefinitions.pdf).

Core component 1: IPC programmes

Facility level: An IPC programme with a dedicated, trained team should be in place in each acute health care facility (strong)

National level: Stand-alone, active national IPC programme with clearly defined objwctives, fucntions and activities as well as linked with relevant national programmes (GPS)

- Clearly defined objectives, functions and annual action plans
- Dedicated, trained IPC professionals (1 IP/250 beds) & multidisciplinary team & linkages to other programmes
- Budget & support from the senior management leadership
- Good quality microbiological laboratory

Minimum requirements: CC1

World Health Organization

	NATIONAL LEVEL	FACILITY LEVEL
MINIMUM REQUIREMENTS	**A functional IPC programme should be in place, including at least:** • one full-time focal point trained in IPC. • a dedicated budget for implementing IPC strategies/plans.	■ **PRIMARY CARE:** **IPC trained health care officer** • Trained IPC link person, with dedicated (part-) time in each primary health care facility. • One IPC-trained health care officer at the next administrative level (for example, district) to supervise the IPC link professionals in primary health care facilities. ■ **SECONDARY CARE:** **functional IPC programme** • Trained IPC focal point (one full-time trained IPC Officer [nurse or doctor]) as per the recommended ratio of 1:250 beds with dedicated time to carry out IPC activities in all facilities (for example, if the facility has 120 beds, one 50% full-time equivalent dedicated officer). • Dedicated budget for IPC implementation. ■ **TERTIARY CARE:** **functional IPC programme** • At least one full-time trained IPC focal point (nurse or doctor) with dedicated time per 250 beds. • IPC programme aligned with the national programme and with a dedicated budget. • Multidisciplinary committee/team. • Access to microbiology laboratory.

Core component 2: IPC guidelines

Evidence-based guidelines should be developed and implemented for the purpose of reducing HAI and AMR. Education & training of relevant HCW on guideline recommendations and monitoring of adherence should be undertaken.

- Strong recommendation (combined national & facility)
- Expertise required
- Local prioritization
- Providing resources for implementation
- HCWs education on recommended practices
- Monitoring implementation

IPC Guidelines

- The **basic set of IPC guidelines** should include the following:
  - **Standard precautions** (see core component 1)
  - **Transmission-based precautions**, including patient identification, placement and the use of personal protective equipment.
  - **Aseptic technique** for invasive procedures (including surgery) and device management for clinical procedures, according to the scope and type of care delivered at the facility level.
  - **Specific guidelines to prevent the most prevalent HAIs** (for example, catheter-associated urinary tract infection, SSI, central line-associated bloodstream infection, ventilator-associated pneumonia) depending on the context and complexity of care.

2. Guidelines & implementation

WHO IPC global guidelines

World Health Organization

http://www.who.int/infection-prevention/en/

Core component 3: IPC education & training

Facility level: IPC education should be in place for all health care workers by utilizing team- and task-based strategies that are participatory and include bedside and simulation training to reduce the risk of HAI and AMR. (strong)

National level: The national IPC programme should support education and training of the health workforce as one of its core functions (GPS)

- **Pre-graduate, post-graduate, in-service** training
- **Evaluations** of training impact
- **Collaboration** with local academic institutions and professional organizations

Minimum requirements: CC3

World Health Organization

	NATIONAL LEVEL	FACILITY LEVEL
MINIMUM REQUIREMENTS	**National training policy and curriculum** • National policy that all HCWs are trained in IPC (in-service training). • An approved IPC national curriculum aligned with national guidelines and endorsed by the appropriate body. • National system and schedule of monitoring and evaluation to check on the effectiveness of IPC training and education (at least annually).	■ **PRIMARY CARE:** **IPC training for all front-line clinical staff and cleaners upon hiring** • All front-line clinical staff and cleaners must receive education and training on the facility IPC guidelines/SOPs upon employment. • All IPC link persons in primary care facilities and IPC officers at the district level (or other administrative level) need to receive specific IPC training. ■ **SECONDARY CARE:** **IPC training for all front-line clinical staff and cleaners upon hire** • All front-line clinical staff and cleaners must receive education and training on the facility IPC guidelines/SOPs upon employment. • All IPC staff need to receive specific IPC training. ■ **TERTIARY CARE:** **IPC training for all front-line clinical staff and cleaners upon hire and annually** • All front-line clinical staff and cleaners must receive education and training on the facility IPC guidelines/SOPs upon employment and annually. • All IPC staff need to receive specific IPC training.

Core component 4: HAI surveillance

Facility level: Facility-based HAI surveillance should be performed to guide IPC interventions and detect outbreaks with timely feedback of results (strong)

National level: National HAI surveillance programmes and networks that include mechanisms for timely data feedback and with the potential to be used for benchmarking (strong)

- **Budget, leadership support and linkages** to other surveillances and health information systems needed
- **Standardized definitions,** appropriate methods, **good quality laboratory support**, quality control needed
- **Training and expertise** needed
- **Timely reporting** and feedback

Minimum requirements: CC4

World Health Organization

	NATIONAL LEVEL	FACILITY LEVEL
MINIMUM REQUIREMENTS	**IPC surveillance and a monitoring technical group** • Establishment by the national IPC focal point of a technical group for HAI surveillance and IPC monitoring that: - is multidisciplinary; - develops a national strategic plan for HAI surveillance (with a focus on priority infections based on the local context) and IPC monitoring.	■ **PRIMARY CARE** • HAI surveillance is not required as a minimum requirement at the primary facility level, but should follow national or sub-national plans, if available (for example, detection and reporting of outbreaks affecting the community is usually included in national plans). ■ **SECONDARY CARE** • HAI surveillance should follow national or sub-national plans. ■ **TERTIARY CARE:** **functional HAI surveillance** • Active HAI surveillance should be conducted and include information on AMR: - enabling structures and supporting resources need to be in place (for example, dependable laboratories, medical records, trained staff), directed by an appropriate method of surveillance; - the method of surveillance should be directed by the priorities/plans of the facility and/or country. • Timely and regular feedback needs to be provided to key stakeholders in order to lead to appropriate action, in particular to the hospital administration.

Core component 5: Multimodal strategies

Facility level: At the facility level IPC activities should be implemented using multimodal strategies to improve practices and reduce HAI & AMR. (strong)

National level: National IPC programmes should coordinate and facilitate the implementation of IPC activities through multimodal strategies on a nationawide or sub-national level. (strong)

A **multimodal strategy** comprises **several elements or components** (3 or more; usually 5) **implemented in an integrated way** with the aim of improving an outcome and changing behaviour. It includes tools, such as bundles and checklists, developed by multidisciplinary teams that **take into account local conditions**.

What is a multimodal strategy?

- ***It is "THE" modern way to implement IPC interventions***
  - ✓ to achieve the change of system, climate and behaviour supporting IPC progress and, ultimately, the measurable impact that benefits patients and health care workers (outcome)
- **Multimodal thinking** means that IPC practitioners do not focus only on single strategies to change practices (for example, training and education), but consider a range of strategies that target different influencers of human behaviour, e.g. procurement, monitoring and feedback, infrastructures or organizational culture.
- All (five) elements should be considered and necessary action taken, based on the local context and situation informed by periodic assessments. "Unimodal" strategies are less likely to result in improvements and are short-lived and not sustainable.

IPC improvement strategy: multimodal thinking

World Health Organization

Figure 5.1 The five components of the WHO multimodal hand hygiene improvement strategy

1a. System change – alcohol-based handrub at point of care

+

1b. System change – access to safe, continuous water supply, soap and towels

+

2. Training and education

+

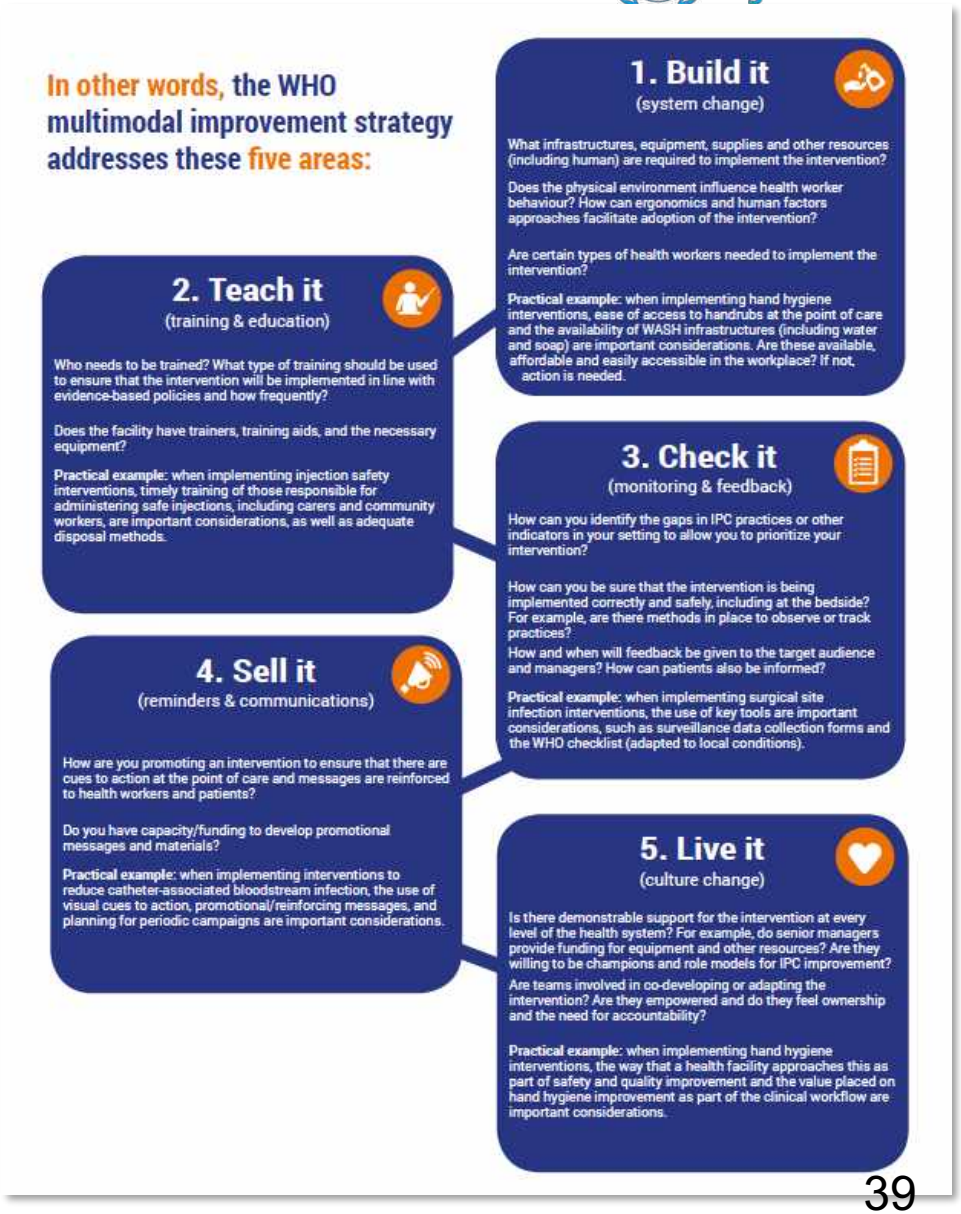
3. Evaluation and feedback

+

4. Reminders in the workplace

+

5. Institutional safety climate



Source: http://www.who.int/infection-prevention/tools/core-components/cc-implementation-guideline.pdf?ua=1

Minimum requirements: CC5

World Health Organization

	NATIONAL LEVEL	FACILITY LEVEL
MINIMUM REQUIREMENTS	**Multimodal improvement strategies for IPC interventions** • Use of multimodal strategies to implement IPC interventions according to national guidelines/SOPs under the coordination of the national IPC focal point (or team, if existing).	■ **PRIMARY CARE: multimodal strategies for priority IPC interventions** • Use of multimodal strategies – at the very least to implement interventions to improve hand hygiene, safe injection practices, decontamination of medical instruments, devices and environmental cleaning. ■ **SECONDARY CARE: multimodal strategies for priority IPC interventions** • Use of multimodal strategies – at the very least to implement interventions to improve each one of the standard and transmission-based precautions, and triage. ■ **TERTIARY CARE: multimodal strategies for all IPC interventions** • Use of multimodal strategies to implement interventions to improve each one of the standard and transmission-based precautions, triage, and those targeted at the reduction of specific infections (for example, surgical site infections or catheter-associated infections) in high-risk areas/patient groups, in line with local priorities.

Core component 6: Monitoring/audit of IPC indicators & feedback

Facility level: Regular monitoring/audit and timely feedback of health care practices should be undertaken according to IPC standards. Feedback should be provided to all audited persons and staff. (strong)

National level: A national IPC monitoring and evaluation programme should be established to assess the extent to which standards are being met and activities performed. Hand hygiene monitoring with feedback should a key performance indicator. (strong)

- To achieve behaviour change or other improvements
- To document progress and impact
- Essential: timely feedback and data interpretation for action
- Integration/alignment with other monitoring systems needed
- Hand hygiene: national KPI

Minimum requirements: CC6

World Health Organization

MINIMUM REQUIREMENTS

NATIONAL LEVEL

IPC surveillance and monitoring technical group

- Establishment by the national IPC focal point of a technical group for HAI surveillance and IPC monitoring that:
  - is multidisciplinary;
  - develops a national strategic plan for HAI surveillance and IPC monitoring and, for IPC indicators monitoring:
    - develops recommendations for minimum indicators (for example, hand hygiene);
    - develops an integrated system for the collection and analysis of data (for example, protocols, tools)
    - provides training at the facility level to collect and analyse these data.

FACILITY LEVEL

PRIMARY CARE

- Monitoring of IPC structural and process indicators should be put in place at primary care level, based on IPC priorities identified in the other components. This requires decisions at the national level and implementation support at the sub-national level.

SECONDARY AND TERTIARY CARE

- A person responsible for the conduct of the periodic or continuous monitoring of selected indicators for process and structure, informed by the priorities of the facility or the country.
- Hand hygiene is an essential process indicator to be monitored.
- Timely and regular feedback needs to be provided to key stakeholders in order to lead to appropriate action, particularly to the hospital administration.

Core Component 7: Workload, staffing & bed occupancy (facility level)

Facility level only: In order to reduce the risk of HA and the spread of AMR the following should be addressed: (1) bed occupancy should not exceed the standard capacity; (2) health care worker staffing levels should be adequately assigned according to patient workload. (strong)

- **Overcrowding** recognized as being a **public health issue** that can lead to disease transmission
- Standards for bed occupancy should be **one patient per bed** with **adequate spacing between beds** (at least 1 metre)
- **HCWs staffing** levels should be adequately assigned according to patient workload

WHO Workload Indicators of Staffing Need (WISN) method
http://www.who.int/hrh/resources/wisn_user_manual/en/

Minimum requirements: CC7 (facility level)

World Health Organization

MINIMUM REQUIREMENTS

PRIMARY CARE

- **To reduce overcrowding:** a system for patient flow, a triage system (including referral system) and a system for the management of consultations should be established according to existing guidelines, if available.
- **To optimize staffing levels:** assessment of appropriate staffing levels, depending on the categories identified when using WHO/national tools (national norms on patient/staff ratio), and development of an appropriate plan.

SECONDARY AND TERTIARY CARE

- **To standardize bed occupancy:**
  - establish a system to manage the use of space in the facility and to establish the standard bed capacity for the facility;
  - hospital administration enforcement of the system developed;
  - no more than one patient per bed;
  - spacing of at least one metre between the edges of beds;
  - overall occupancy should not exceed the designed total bed capacity of the facility.
- **To reduce overcrowding and optimizing staffing levels:** same *minimum requirements* as for primary health care.

* The **national health system, IPC programme and any other relevant body** should coordinate and support the implementation of this core component at the facility level.

Core Component 8: Built environment, materials & equipment for IPC (facility level)

At the facility level patient care activities should be undertaken in a clean and/or hygienic environment that facilitates practices related to the prevention and control of HAI, as well as AMR, including all elements around the WASH infrastructure and services and the availability of appropriate IPC materials and equipment. *(GPS)*

At the facility level, materials and equipment to perform appropriate hand hygiene should be readily available at the point of care. (strong)

- All requirements to achieve **appropriate clean and hygienic environment, WASH services,** and **materials and equipment for IPC,** in particular for HH

WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. Joint Monitoring Programme definitions of improved water/sanitation. 2019;
WHO. Guidelines on sanitation and health. 2018;
WHO. Essential environmental health standards in health care. 2008;
WHO. Safe management of wastes from health care. 2014;

Minimum requirements: CC8 (facility level*)

MINIMUM REQUIREMENTS

PRIMARY CARE:

- Water should always be available from a source on the premises (such as a a deep borehole or a treated, safely managed piped water supply) to perform basic IPC measures, including hand hygiene, environmental cleaning, laundry, decontamination of medical devices and health care waste management according to national guidelines.
- A minimum of two functional, improved sanitation facilities should be available on-site, one for patients and the other for staff; both should be equipped with menstrual hygiene facilities.
- Functional hand hygiene facilities should always be available at points of care/toilets and include soap, water and single-use towels (or if unavailable, clean reusable towels) or alcohol-based handrub (ABHR) at points of care and soap, water and single-use towels (or if unavailable, clean reusable towels) within 5 metres of toilets.
- Sufficient and appropriately labelled bins to allow for health care waste segregation should be available and used (less than 5 metres from point of generation); waste should be treated and disposed of safely via autoclaving, high temperature incineration, and/or buried in a lined, protected pit.
- The facility layout should allow adequate natural ventilation, decontamination of reusable medical devices, triage and space for temporary cohorting/isolation/physical separation if necessary.
- Sufficient and appropriate IPC supplies and equipment (for example, mops, detergent, disinfectant, personal protective equipment (PPE) and sterilization) and power/energy (for example, fuel) should be available for performing all basic IPC measures according to *minimum requirements*/SOPs, including all standard precautions, as applicable; lighting should be available during working hours for providing care.

- WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene. Joint Monitoring Programme definitions of improved water/sanitation. 2019;
- WHO. Guidelines on sanitation and health. 2018;
- WHO. Essential environmental health standards in health care. 2008;
- WHO. Safe management of wastes from health care. 2014;

* The **national health system, IPC programme and any other relevant body** should coordinate and support the implementation of this core component at the facility level.

Minimum requirements: CC8 (facility level*)

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SECONDARY AND TERTIARY CARE:

- A safe and sufficient quantity of water should be available for all required IPC measures and specific medical activities, including for drinking, and piped inside the facility at all times - at a minimum to high-risk wards (for example, maternity ward, operating room/s, intensive care unit).
- A minimum of two functional, improved sanitation facilities that safely contain waste available for outpatient wards should be available and one per 20 beds for inpatient wards; all should be equipped with menstrual hygiene facilities.
- Functional hand hygiene facilities should always be available at points of care, toilets and service areas (for example, the decontamination unit), which include ABHR and soap, water and single-use towels (or if unavailable, clean reusable towels) at points of care and service areas, and soap, water and single-use towels (or if unavailable, clean reusable towels) within 5 metres of toilets.
- Sufficient and appropriately labelled bins to allow for health care waste segregation should be available and used (less than 5 metres from point of generation) and waste should be treated and disposed of safely via autoclaving, incineration (850° to 1100°C), and/or buried in a lined, protected pit.
- The facility should be designed to allow adequate ventilation (natural or mechanical, as needed) to prevent transmission of pathogens.
- Sufficient and appropriate supplies and equipment and reliable power/energy should be available for performing all IPC practices, including standard and transmission-based precautions, according to *minimum requirements*/SOPs; reliable electricity should be available to provide lighting to clinical areas for providing continuous and safe care, at a minimum to high-risk wards (for example, maternity ward, operating room/s, intensive care unit).
- The facility should have a dedicated space/area for performing the decontamination and reprocessing of medical devices (that is, a decontamination unit) according to *minimum requirements*/SOPs.
- The facility should have adequate single isolation rooms or at least one room for cohorting patients with similar pathogens or syndromes, if the number of isolation rooms is insufficient

* The **national health system, IPC programme and any other relevant body** should coordinate and support the implementation of this core component at the facility level.

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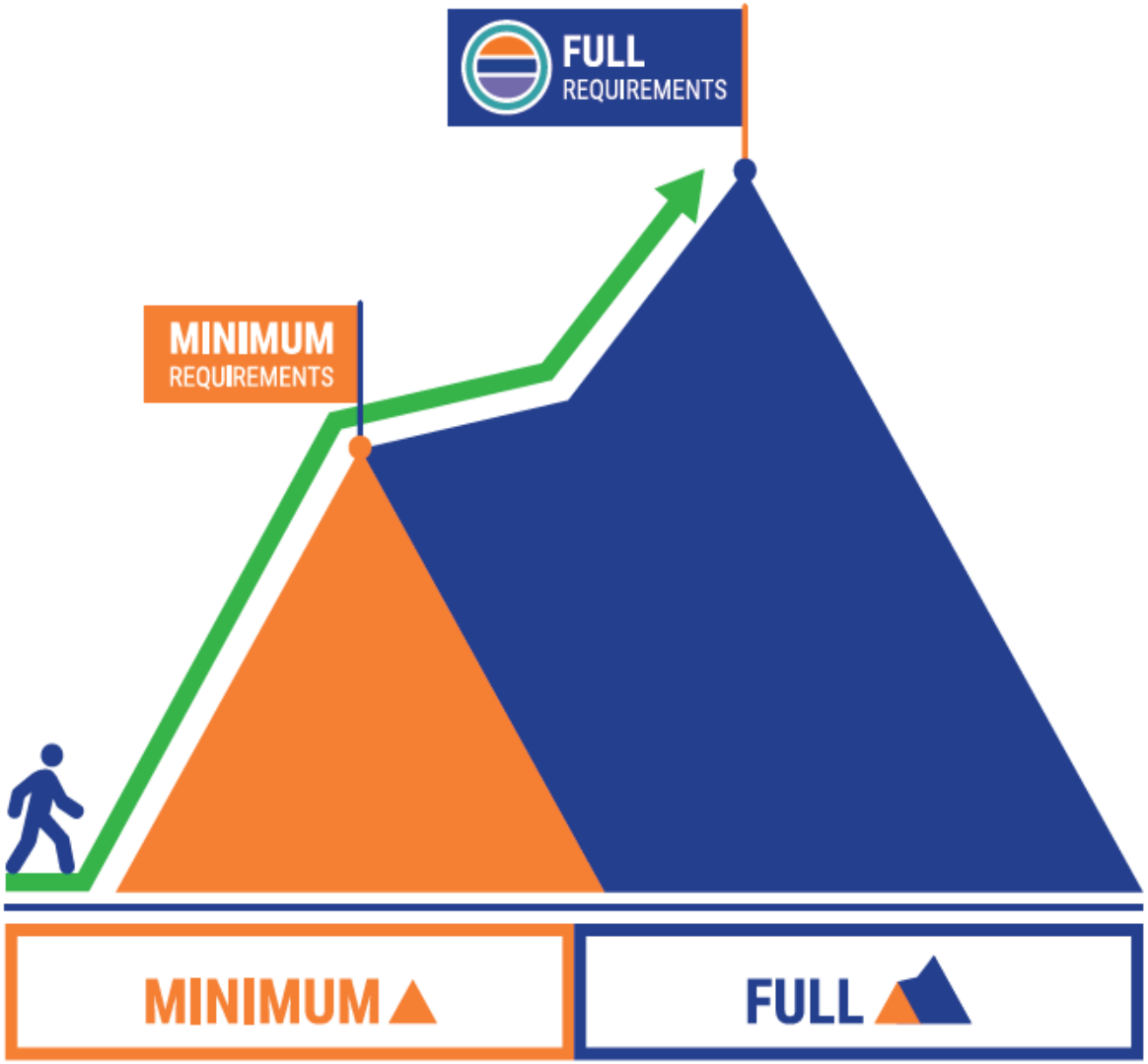

IPC to reduce burden of AMR

An advocacy document aimed at policy-makers

- Provides shocking data on the health and economic impact of HAIs and AMR
- IPC is cost-saving in controlling AMR and saves lives
- Patient story from Vanessa Carter, who was harmed by an antibiotic-resistant health care-associated infection
- Role of IPC in attaining Universal Health Coverage
- Central role of IPC core components and introduction to the IPC minimum requirements
- https://www.who.int/infection-prevention/tools/focus-amr/en/

WHO IPC Training Package

- **Leadership and IPC program management**
- **Prevention of urinary tract infections**
- Prevention of catheter-associated bloodstream infections
- Prevention of respiratory tract infections
- **Prevention of surgical site infections**
- **Reprocessing of medical devices**
- Outbreak management in healthcare settings
- **IPC to control antibiotic resistance**
- **HAI surveillance**
- **Injection safety**

- **Slides deck**
- **Trainer's manual**
- **Student's handbook**
- **Videos**
- **E-learning module**

https://www.who.int/infection-prevention/en/

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THANK YOU

WHO Infection Prevention and Control

Learn more at: http://www.who.int/infection-prevention/en/