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Draft global action plan on infection prevention and control

Draft global action plan and monitoring framework: minimum requirements for IPC programmes at national and health care facility levels

Report by the Director-General

In 2019 WHO published minimum requirements for infection prevention and control (IPC).[1] The following Annex, taken from the executive summary of that document, tabulates those minimum requirements for IPC programmes at national level and in different types of acute health care facilities. The aim is that good IPC programmes and practices will enable health care-associated infections to be prevented and the development and spread of antimicrobial resistance to be combated.

[1] WHO. Minimum requirements for infection prevention and control programmes. Geneva: World Health Organization; 2019 (https://iris.who.int/handle/10665/330080, accessed 21 November 2023).

ANNEX

MINIMUM REQUIREMENTS FOR IPC PROGRAMMES AT NATIONAL AND HEALTH CARE FACILITY LEVELS

<table>
<tr><th colspan="2">Core component 1: IPC programmes – Minimum requirements</th></tr>
<tr><th>National level</th><th>Facility level</th></tr>
<tr><td rowspan="3">A functional IPC programme should be in place, including at least:
one full-time focal point trained in IPC; and
a dedicated budget for implementing IPC strategies/plans</td><td>Primary care: IPC-trained health care officer
A 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</td></tr>
<tr><td>Secondary care: functional IPC programme
A trained IPC focal point (one full-time trained IPC officer [for example, nurse or doctor]) at 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</td></tr>
<tr><td>Tertiary care: functional IPC programme
At least one full-time trained IPC officer (nurse or doctor) with dedicated time per 250 beds
IPC programme aligned with the national programme and allocated a dedicated budget
Multidisciplinary committee/team
Access to microbiology laboratory</td></tr>
<tr><th colspan="2">Core component 2: National and facility level IPC guideline – Minimum requirements</th></tr>
<tr><th>National level</th><th>Facility level</th></tr>
<tr><td>National IPC guidelines
Evidence-based, health ministry-approved guidelines adapted to the local context and reviewed at least every five years</td><td>Primary care: facility-adapted standard operating procedures (SOPs) and their monitoring
Evidence-based facility-adapted SOPs based on the national IPC guidelines
As a minimum, the facility SOPs should include:
hand hygiene
decontamination of medical devices and patient care equipment
environmental cleaning
health care waste management
injection safety
health care worker protection (for example, at least post-exposure prophylaxis, vaccinations)
aseptic techniques
triage of infectious patients
basic principles of standard and transmission-based precautions
Routine monitoring of the implementation of at least some of the IPC guidelines/SOPs</td></tr>
</table>

	Secondary and tertiary care: all requirements as for the primary health care facility level, with additional SOPs on: • standard and transmission-based precautions (for example, detailed, specific SOPs for the prevention of airborne pathogen transmission) • aseptic technique for invasive procedures, including surgery • specific SOPs to prevent the most prevalent HAIs based on the local context/epidemiology • occupational health
Core component 3: IPC education and training – Minimum requirements	
National level	**Facility level**
National training policy and curriculum • National policy that all health care workers 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 hiring • 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 hiring 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 – Minimum requirements	
National level	**Facility level**
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; and – 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 subnational plans, if available (for example, detection and reporting of outbreaks affecting the community are usually included in national plans)
	Secondary care • HAI surveillance should follow national or subnational plans
	Tertiary care: functional HAI surveillance • Active HAI surveillance should be conducted and include information on antimicrobial resistance: – enabling structures and supporting resources need to be in place (for example, dependable laboratories, medical records and trained staff), directed by an appropriate method of surveillance; and – 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 particular the hospital administration, in order to lead to appropriate action

<table>
<tr><th colspan="2">Core component 5: Multimodal improvement strategies for implementing IPC activities – Minimum requirements</th></tr>
<tr><th>National level</th><th>Facility level</th></tr>
<tr><td rowspan="3">Multimodal improvement strategies for IPC interventions
Multimodal strategies should be used to implement IPC interventions according to national guidelines/SOPs under the coordination of the national IPC focal point (or team, if existing)</td><td>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 and devices and environmental cleaning</td></tr>
<tr><td>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</td></tr>
<tr><td>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</td></tr>
<tr><th colspan="2">Core component 6: IPC monitoring, evaluation and feedback – Minimum requirements</th></tr>
<tr><th>National level</th><th>Facility level</th></tr>
<tr><td rowspan="2">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 and IPC monitoring; and develops an integrated system for the collection and analysis of data (for example, protocols and tools)
provides training at the facility level to collect and analyse these data
develops recommendations for minimum indicators (for example, hand hygiene)</td><td>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 subnational level</td></tr>
<tr><td>Secondary and tertiary care
There should be 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 the hospital administration</td></tr>
<tr><th colspan="2">Core component 7: Workload, staffing and bed occupancy at the facility level – Minimum requirements</th></tr>
<tr><td colspan="2">Primary care facility
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: assess whether staffing levels are appropriate, depending on the categories identified when using WHO’s and/or national tools (national norms on patient/staff ratio), and develop an appropriate plan</td></tr>
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Secondary and tertiary care facilities

- 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
  - ensure hospital administration's enforcement of the system developed; and ensure no more than one patient per bed
  - provide spacing at least one metre between the edges of beds; and ensure overall occupancy does not exceed the designed total bed capacity of the facility
- To reduce overcrowding and to optimize staffing levels: apply the same minimum requirements as for primary health care

Core component 8: Built environment, materials and equipment for IPC at the facility level – Minimum requirements

Primary care facility

- Water should always be available from a source on the premises (such as 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 hand rub at points of care and soap, water and single-use towels (or if unavailable, clean reusable towels) within five metres of toilets
- Sufficient and appropriately-labelled bins to allow for segregation of health care waste should be available and used (less than five metres from point of generation); waste should be treated and disposed of safely by autoclaving, high-temperature incineration, and/or burial 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 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

Secondary and tertiary care facilities

- A safe and sufficient quantity of water should be available for all required IPC measures and specific medical activities, including supplies for drinking, and piped inside the facility at all times – at a minimum to high-risk wards (for example, maternity wards, operating rooms and intensive care units)
- A minimum of two functional, improved sanitation facilities that safely contain waste should be available for outpatient wards 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, decontamination units), which include alcohol-based hand rub 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 five metres of toilets
- Sufficient and appropriately labelled bins to allow for segregation of health care waste should be available and used (less than five metres from point of generation) and waste should be treated and disposed of safely by autoclaving, incineration (at 850 to 1100 °C), and/or burial 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 performance of all IPC practices, including standard and transmission-based precautions, according to WHO's Minimum requirements for infection prevention and control programmes /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 wards, operating rooms and intensive care units)
- The facility should have a dedicated space/area for performing the decontamination and reprocessing of medical devices (that is, a decontamination unit) according to WHO's minimum requirements for infection prevention and control programmes /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