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Chapter 1 : WHO | WHO compendium of innovative health technologies for low-resource settings

The idea for this Compendium was developed at a meeting of leaders of community aging initiatives at the v Compendium of Community Aging Initiatives.

This article has been republished " A compendium of strategies to prevent healthcare-associated infections in acute care hospitals: See other articles in PMC that cite the published article. Despite improvements, preventable HAIs continue to occur. The updates to the Compendium were created to provide acute care hospitals with up-to-date, practical, expert guidance to assist in prioritizing and implementing their HAI prevention efforts. Better Care, Lower Costs, aimed at improving the quality, safety, and affordability of US healthcare. Despite these advancements, HAIs continue to affect about 1 out of every 25 hospitalized patients, leading to substantial morbidity, mortality, and excess healthcare expenditures, 12 and there are persistent gaps between recommendations and practice. The following is a summary of the strategies to prevent HAIs in acute care hospitals presented in the Compendium updates. Criteria for classifying recommendations as basic practices versus special approaches and for grading the quality of supporting evidence are described below. High Highly confident that the true effect lies close to that of the estimated size and direction of the effect. Evidence is rated as high quality when there is a wide range of studies with no major limitations, there is little variation between studies, and the summary estimate has a narrow confidence interval. Moderate The true effect is likely to be close to the estimated size and direction of the effect, but there is a possibility that it is substantially different. Evidence is rated as moderate quality when there are only a few studies and some have limitations but not major flaws, there is some variation between studies, or the confidence interval of the summary estimate is wide. Low The true effect may be substantially different from the estimated size and direction of the effect. Evidence is rated as low quality when supporting studies have major flaws, there is important variation between studies, the confidence interval of the summary estimate is very wide, or there are no rigorous studies, only expert consensus. Ensure that only trained, dedicated personnel insert urinary catheters quality of evidence: Ensure that supplies necessary for aseptic technique for catheter insertion are available and conveniently located quality of evidence: Implement a system for documenting the following in the patient record: Record criteria for removal and justification for continued use quality of evidence: Ensure that there are sufficient trained personnel and technology resources to support surveillance for catheter use and outcomes quality of evidence: Perform surveillance for CAUTI if indicated on the basis of facility risk assessment or regulatory requirements Identify the patient groups or units in which to conduct surveillance on the basis of risk assessment, considering frequency of catheter use and potential risk eg, types of surgery, obstetrics, critical care; quality of evidence: Collect information on catheter-days and patient-days denominator data and indications for catheter insertion for all patients in the patient groups or units being monitored quality of evidence: Use surveillance methods for case finding that are documented to be valid and appropriate for the institution quality of evidence: Consider providing unit-specific feedback quality of evidence: Provide education and training Educate healthcare personnel HCP involved in the insertion, care, and maintenance of urinary catheters about CAUTI prevention, including alternatives to indwelling catheters, and procedures for catheter insertion, management, and removal quality of evidence: Assess healthcare professional competency in catheter use, catheter care, and maintenance quality of evidence: Use appropriate technique for catheter insertion Insert urinary catheters only when necessary for patient care and leave in place only as long as indications remain quality of evidence: Consider other methods for bladder management, such as intermittent catheterization, where appropriate quality of evidence: Practice hand hygiene based on CDC or World Health Organization [WHO] guidelines immediately before insertion of the catheter and before and after any manipulation of the catheter site or apparatus quality of evidence: Insert catheters following aseptic technique and using sterile equipment quality of evidence: Use sterile gloves, drape, and sponges; a sterile or antiseptic solution for cleaning the urethral meatus; and a sterile single-use packet of lubricant jelly for insertion quality of evidence: Use as small a catheter as possible consistent with proper drainage, to minimize urethral trauma quality of evidence: Ensure appropriate management of indwelling catheters Properly secure

indwelling catheters after insertion to prevent movement and urethral traction quality of evidence: Maintain a sterile, continuously closed drainage system quality of evidence: Replace the catheter and the collecting system using aseptic technique when breaks in aseptic technique, disconnection, or leakage occur quality of evidence: Obtain larger volumes of urine for special analyses aseptically from the drainage bag quality of evidence: Maintain unobstructed urine flow quality of evidence: Employ routine hygiene; cleaning the meatal area with antiseptic solutions is unnecessary quality of evidence: Special approaches for preventing CAUTI Implement an organization-wide program to identify and remove catheters that are no longer necessary using one or more methods documented to be effective quality of evidence: Develop a protocol for management of postoperative urinary retention, including nurse-directed use of intermittent catheterization and use of bladder scanners quality of evidence: Establish a system for analyzing and reporting data on catheter use and adverse events from catheter use quality of evidence: Use contact precautions for infected patients, single-patient room preferred quality of evidence: Ensure cleaning and disinfection of equipment and the environment quality of evidence: Implement a laboratory-based alert system to provide immediate notification to infection prevention and control and clinical personnel about newly diagnosed CDI patients quality of evidence: Educate patients and their families about CDI as appropriate quality of evidence: During outbreaks or in settings with hyperendemic CDI, perform hand hygiene with soap and water as the preferred method before exiting the room of a patient with CDI quality of evidence: Place patients with diarrhea under contact precautions while C. Prolong the duration of contact precautions after the patient becomes asymptomatic until hospital discharge quality of evidence: Approaches to minimize C. Use an Environmental Protection Agencyâ€”approved sporicidal disinfectant or diluted sodium hypochlorite for environmental cleaning and disinfection. Implement a system to coordinate with environmental services if it is determined that sodium hypochlorite is needed for environmental disinfection quality of evidence: Approaches to reduce the risk of CDI if C. Do not remove hair at the operative site unless the presence of hair will interfere with the operation. Do not use razors quality of evidence: Control blood glucose during the immediate postoperative period for cardiac surgery patients quality of evidence: I and noncardiac surgery patients quality of evidence: Maintain normothermia temperature of Optimize tissue oxygenation by administering supplemental oxygen during and immediately following surgical procedures involving mechanical ventilation quality of evidence: Use alcohol-containing preoperative skin preparatory agents if no contraindication exists quality of evidence: Use impervious plastic wound protectors for gastrointestinal and biliary tract surgery quality of evidence: Use a checklist based on the WHO checklist to ensure compliance with best practices to improve surgical patient safety quality of evidence: Perform surveillance for SSI quality of evidence: Increase the efficiency of surveillance through utilization of automated data quality of evidence: Provide ongoing feedback of SSI rates to surgical and perioperative personnel and leadership quality of evidence: Measure and provide feedback to providers regarding rates of compliance with process measures quality of evidence: Educate surgeons and perioperative personnel about SSI prevention quality of evidence: Educate patients and their families about SSI prevention as appropriate quality of evidence: Implement policies and practices aimed at reducing the risk of SSI that align with evidence-based standards eg, CDC, Association for periOperative Registered Nurses, and professional organization guidelines; quality of evidence: Perform antiseptic wound lavage quality of evidence: Perform an SSI risk assessment quality of evidence: Observe and review operating room personnel and the environment of care in the operating room quality of evidence: Bathe ICU patients over 2 months of age with a chlorhexidine preparation on a daily basis quality of evidence: At insertion Have a process in place to ensure adherence to infection prevention practices at the time of CVC insertion in ICU and non-ICU settings, such as a checklist quality of evidence: Perform hand hygiene prior to catheter insertion or manipulation quality of evidence: Avoid using the femoral vein for central venous access in obese adult patients when the catheter is placed under planned and controlled conditions quality of evidence: Use an all-inclusive catheter cart or kit quality of evidence: Use ultrasound guidance for internal jugular catheter insertion quality of evidence: Use maximum sterile barrier precautions during CVC insertion quality of evidence: Use an alcoholic chlorhexidine antiseptic for skin preparation quality of evidence: After insertion Ensure appropriate nurse-to-patient ratio and limit the use of float nurses in ICUs quality of evidence:

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Disinfect catheter hubs, needleless connectors, and injection ports before accessing the catheter quality of evidence: Remove nonessential catheters quality of evidence: For nontunneled CVCs in adults and children, change transparent dressings and perform site care with a chlorhexidine-based antiseptic every 5â€”7 days or immediately if the dressing is soiled, loose, or damp; change gauze dressings every 2 days or earlier if the dressing is soiled, loose, or damp quality of evidence: Replace administration sets not used for blood, blood products, or lipids at intervals not longer than 96 hours quality of evidence: Use antimicrobial ointments for hemodialysis catheter-insertion sites quality of evidence: Use chlorhexidine-containing dressings for CVCs in patients over 2 months of age quality of evidence: Use silver zeoliteâ€”impregnated umbilical catheters in preterm infants in countries where it is approved for use in children; quality of evidence: Use antimicrobial locks for CVCs quality of evidence: Use recombinant tissue plasminogen activating factor once weekly after hemodialysis in patients undergoing hemodialysis through a CVC quality of evidence: Implement an MRSA monitoring program quality of evidence: Provide MRSA data and outcome measures to key stakeholders, including senior leadership, physicians, nursing staff, and others quality of evidence: Educate patients and their families about MRSA quality of evidence: Provide universal decolonization to ICU patients quality of evidence: Use of gowns and gloves for all contact with patients and the patient care environment Use gowns and gloves when providing care to or entering the room of adult ICU patients quality of evidence: Minimize sedation Manage ventilated patients without sedatives whenever possible quality of evidence: Interrupt sedation once a day spontaneous awakening trials for patients without contraindications quality of evidence: Assess readiness to extubate once a day spontaneous breathing trials in patients without contraindications quality of evidence: Pair spontaneous breathing trials with spontaneous awakening trials quality of evidence: Maintain and improve physical conditioning Provide early exercise and mobilization quality of evidence: Minimize pooling of secretions above the endotracheal tube cuff Provide endotracheal tubes with subglottic secretion drainage ports for patients likely to require greater than 48 or 72 hours of intubation quality of evidence:

Chapter 2 : Compendium of Questionnaires: 3 Volume Set - Electronic Delivery

3 Care Coordination Care coordination is the management of communication and transactions between multiple health care providers who care for the same patient.

Chapter 3 : Compendium of Sustainable Development Indicator Initiatives | IISD

Compendium of project initiatives 3 The estimated prioritized funding required through voluntary contributions for the sixteenth financial period () totals CHF million.