SGInf/SGSH/SSM – Jahreskonferenz 2024, Bern

Infektionsprävention mehr als 50 Jahre

Meilensteine und Visionen

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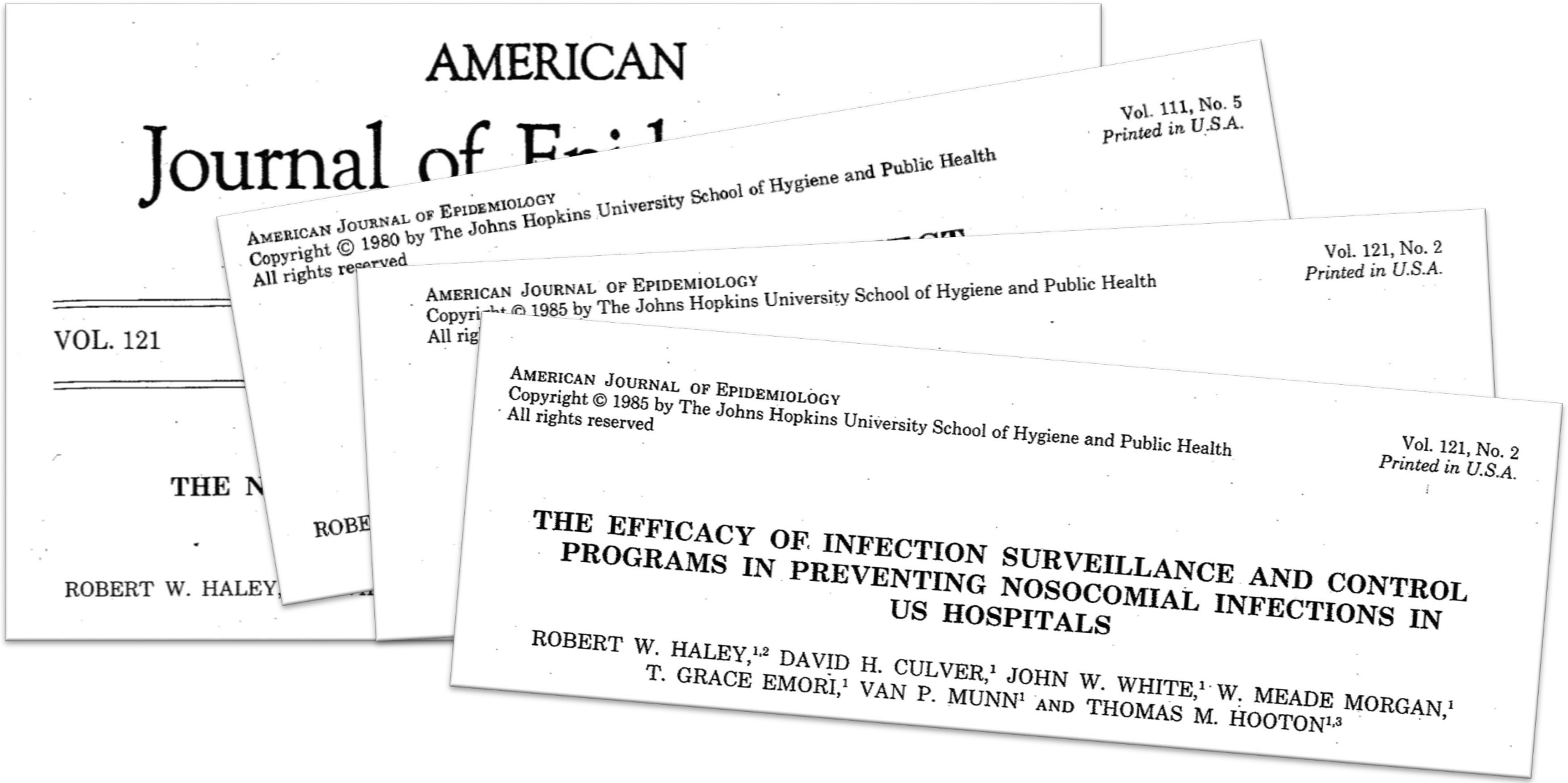
USZ Universitäts Spital Zürich

Die “SENIC” Studie

Study on the Efficacy of Nosocomial Infection Control



Hypothese

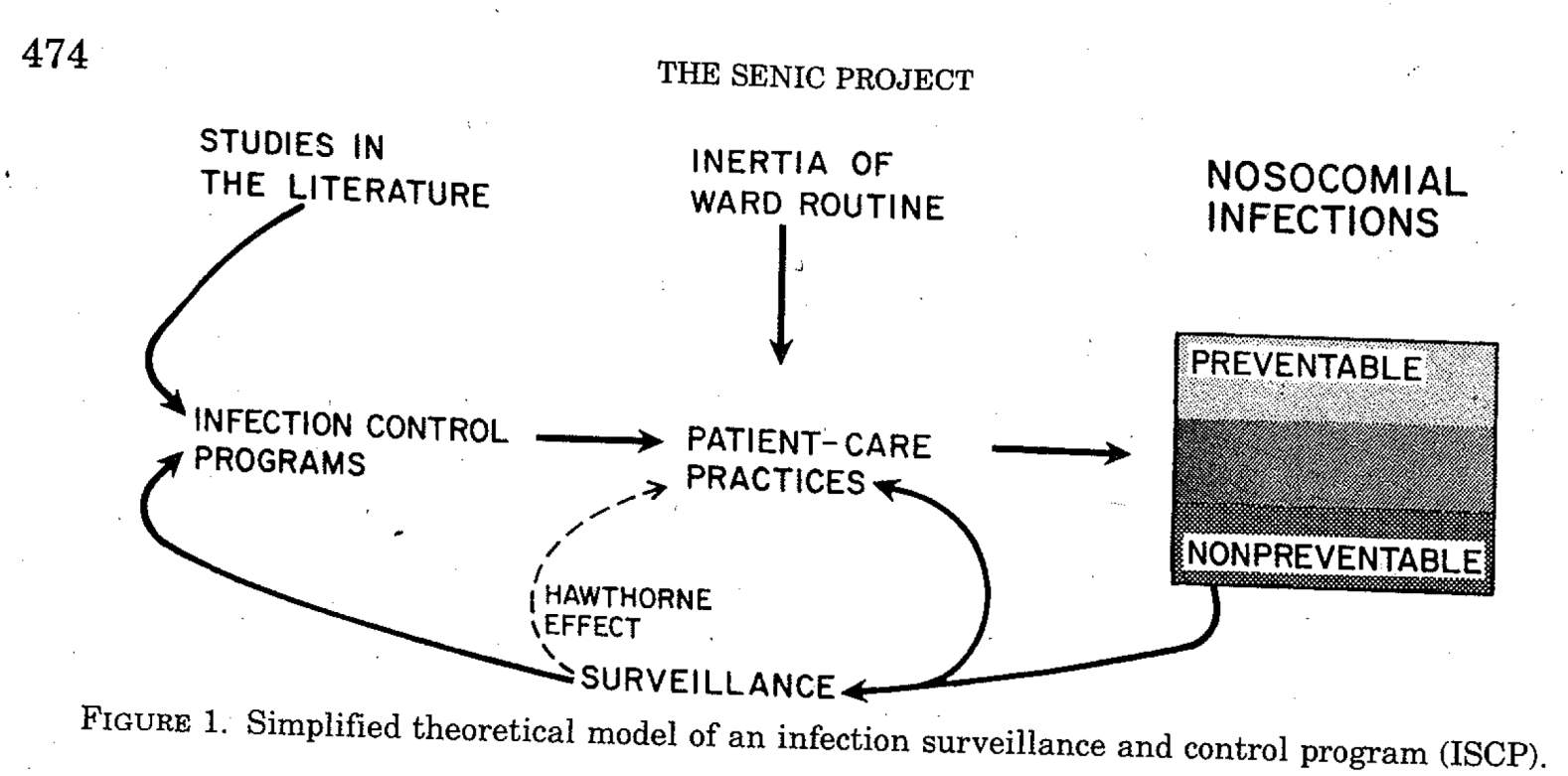


FIGURE 1. Simplified theoretical model of an infection surveillance and control program (ISCP).

- 1 Spitalhygienische Fachkraft pro 250 Betten
- 1 Epidemiologe
- Mikrobiologische Unterstützung
- IT-Support

→ *Surveillance*
→ *Prävention healthcare-assoziierte Infektionen*

Haley RW *J Epidemiol* 1980;111:472

Nationales Projekt zur Evaluation spitalhygienischer und präventiver Massnahmen

Ursprüngliches Projekt

- Spitäler ohne Spitalhygiene sollten in eine Interventions- und eine Kontrollgruppe randomisiert werden
- Die Intervention sollte ein Programm sein, das Infektionsüberwachung und –Prävention kombiniert
- Healthcare-assoziierte Infektionen sollten prospektiv über mehrere Jahre gemessen werden

Durchgeführte Studie: quasi-experimentelle Studie in drei Phasen

- Phase I: Fragebogen zur Erfassung aktueller Aktivitäten hinsichtlich Infektionsüberwachung und –Prävention
- Phase II: Interviews mit den Spitälern, um die Informationen aus dem Fragebogen zu vertiefen und zu definieren, was Infektionsüberwachung und –Prävention konkret bedeuten
- Phase III: Abschätzung der Infektionsinzidenz anhand von Krankenakten im Jahr vor Einführung der «Intervention» und im aktuellsten Jahr der Informationserfassung

Phase I

Fragebogen zur Einschätzung der Umsetzung von Infektionsüberwachung und –Prävention

Einladung aller 6586 Akutkrankenhäuser in den USA

*Rücklauf: 86% (3599) der «SENIC Universe of hospitals»**

**Medizinische und chirurgische Allgemein-krankenhäuser mit >50 Betten in 48 Staaten*

Haley RW *J Epidemiol* 1980;111:472

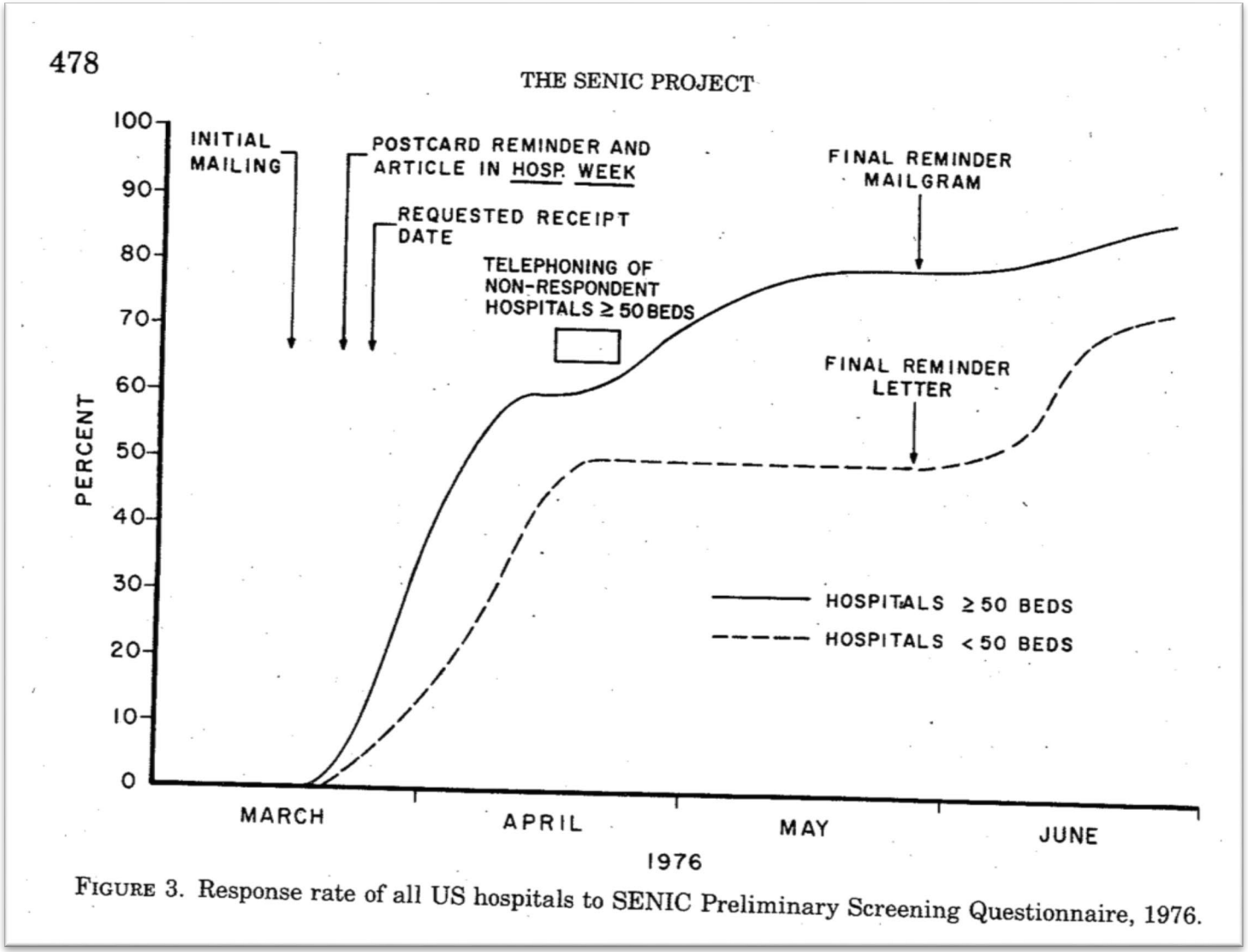


FIGURE 3. Response rate of all US hospitals to SENIC Preliminary Screening Questionnaire, 1976.

Phase II

Persönliche **Interviews** mit relevanten Akteuren (i.d.R 12) in den Spitälern

Detailliertere Abschätzung der Umsetzung von Massnahmen in Infektionsüberwachung und –Prävention

TABLE 1

Number of hospital personnel interviewed and average duration of their interviews among the 433 hospitals in the Hospital Interview Survey (Phase II) of the SENIC Project

Hospital personnel	No. of persons interviewed	Average (±SD) interview time (minutes)
1. Chairperson of the infection control committee and/or HE*	488	86 (±26)
2. ICN† (if none, the nursing representative on the infection control committee or other most knowledgeable infection control person)	465	176 (±49)‡
3. Hospital Administrator (or Assistant Administrator more directly in charge of infection control)	437	20 (±7)
4. Director of the Microbiology Laboratory	435	24 (±9)
5. Technicians in the Microbiology Laboratory	432	17 (±6)
6. Director of the Nursing Service	447	15 (±5)
7. Operating Room Supervisor	437	25 (±8)
8. Head of Pharmacy	435	7 (±4)
9. Head of Inhalation Therapy	430	15 (±5)
10. Head of Intravenous Team (if IV team present)	121	15 (±5)
11. Head of Housekeeping	439	13 (±5)
12. Person in charge of cleaning anesthesia equipment	434	10 (±5)
13. Sample of the nursing staff	7188	50¶
TOTAL	12,969	

* HE = hospital epidemiologist.
† ICN = infection control nurse.
‡ This interview had a scheduled break at approximately the midpoint to reduce the adverse effects of fatigue.
¶ Estimated.

Haley RW *J Epidemiol* 1980;111:472

Phase III

Vergleich der **Inzidenz** healthcare-assoziierter Infektionen im Jahr, bevor das Spital Massnahmen zu Infektionsüberwachung und –Prävention eingeführt hatte, mit dem aktuellsten Jahr der Informationserhebung (De facto wurde 1970 als Baseline und April 1975 bis März 1976 als Outcome-Periode gewählt)

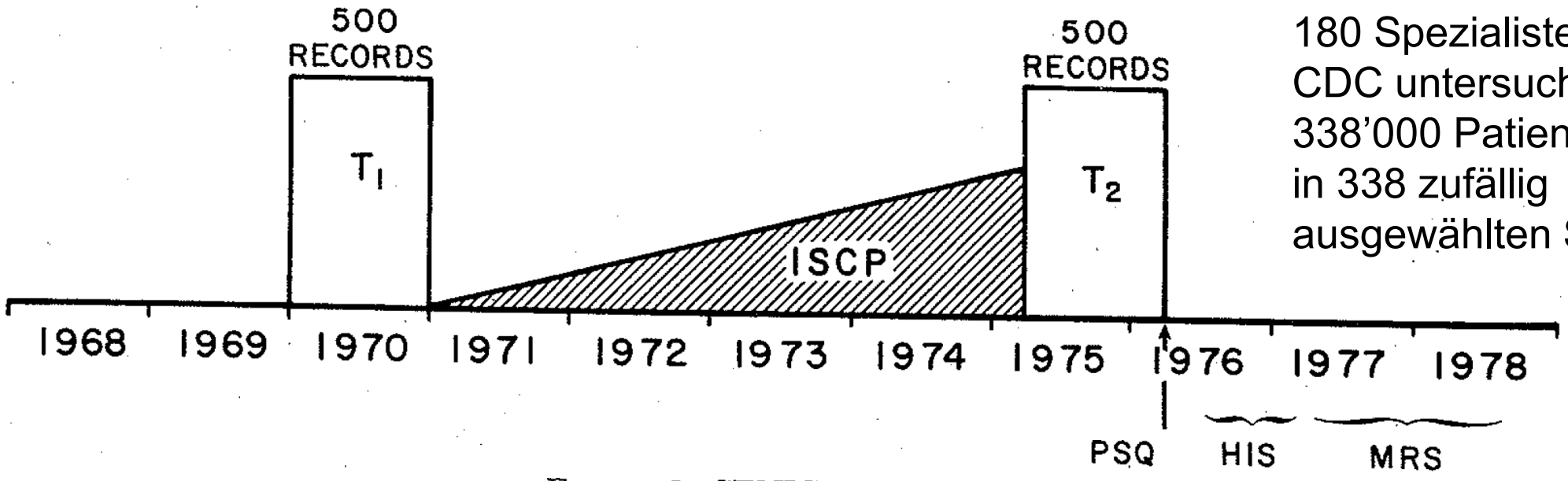


FIGURE 2. SENIC study design.

180 Spezialisten der CDC untersuchten 338'000 Patientenakten in 338 zufällig ausgewählten Spitälern!

Haley RW *J Epidemiol* 1980;111:472

Analyse

Umsetzung von **Infektionsüberwachung** und –**Prävention** der Phasen I & II

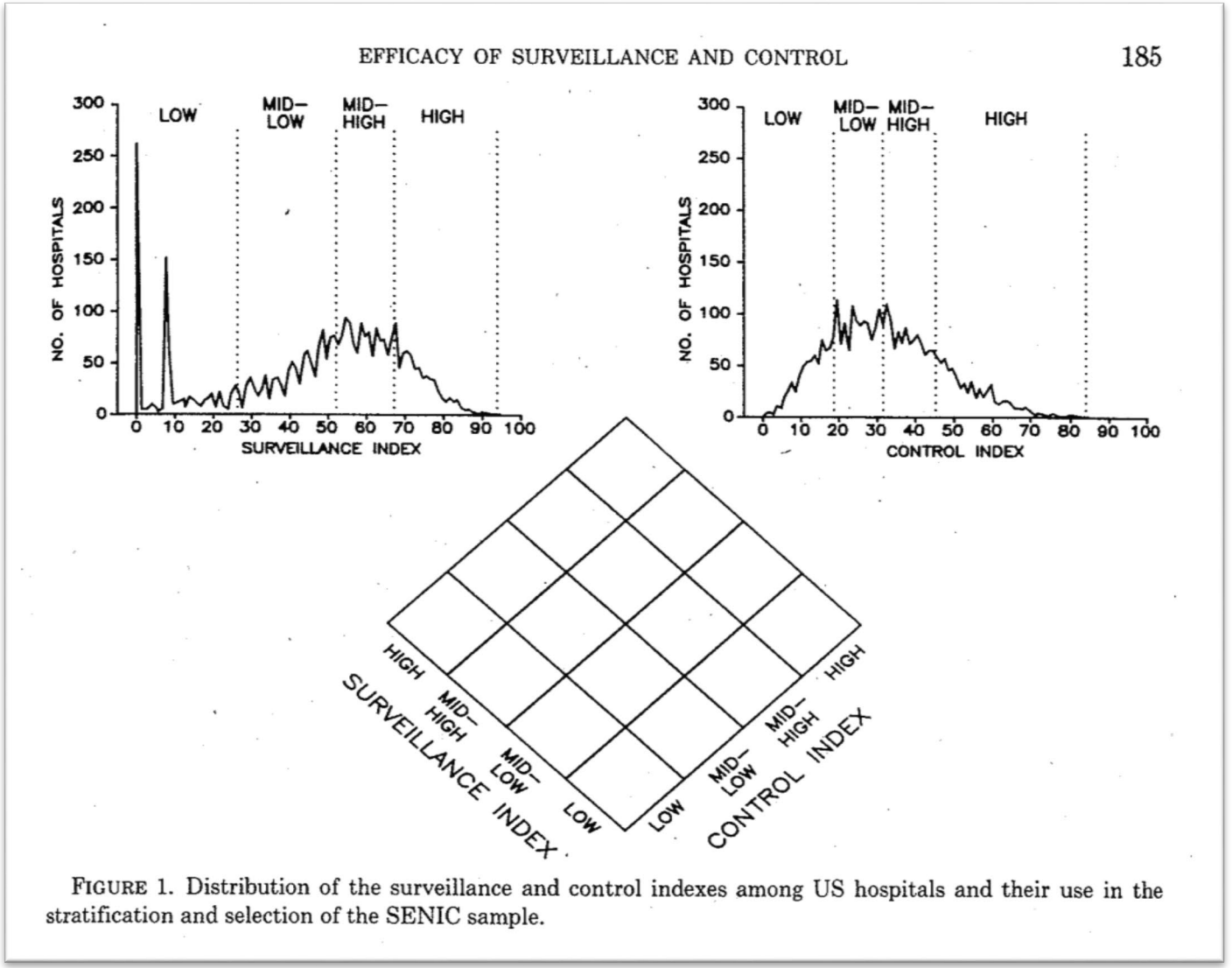


FIGURE 1. Distribution of the surveillance and control indexes among US hospitals and their use in the stratification and selection of the SENIC sample.

Haley RW *J Epidemiol* 1985;121:182

Analyse

TABLE 6

Percentage change in nationwide nosocomial infection rates from 1970 to 1975–1976 among hospitals that established infection surveillance and control programs (ISCP) of differing quality

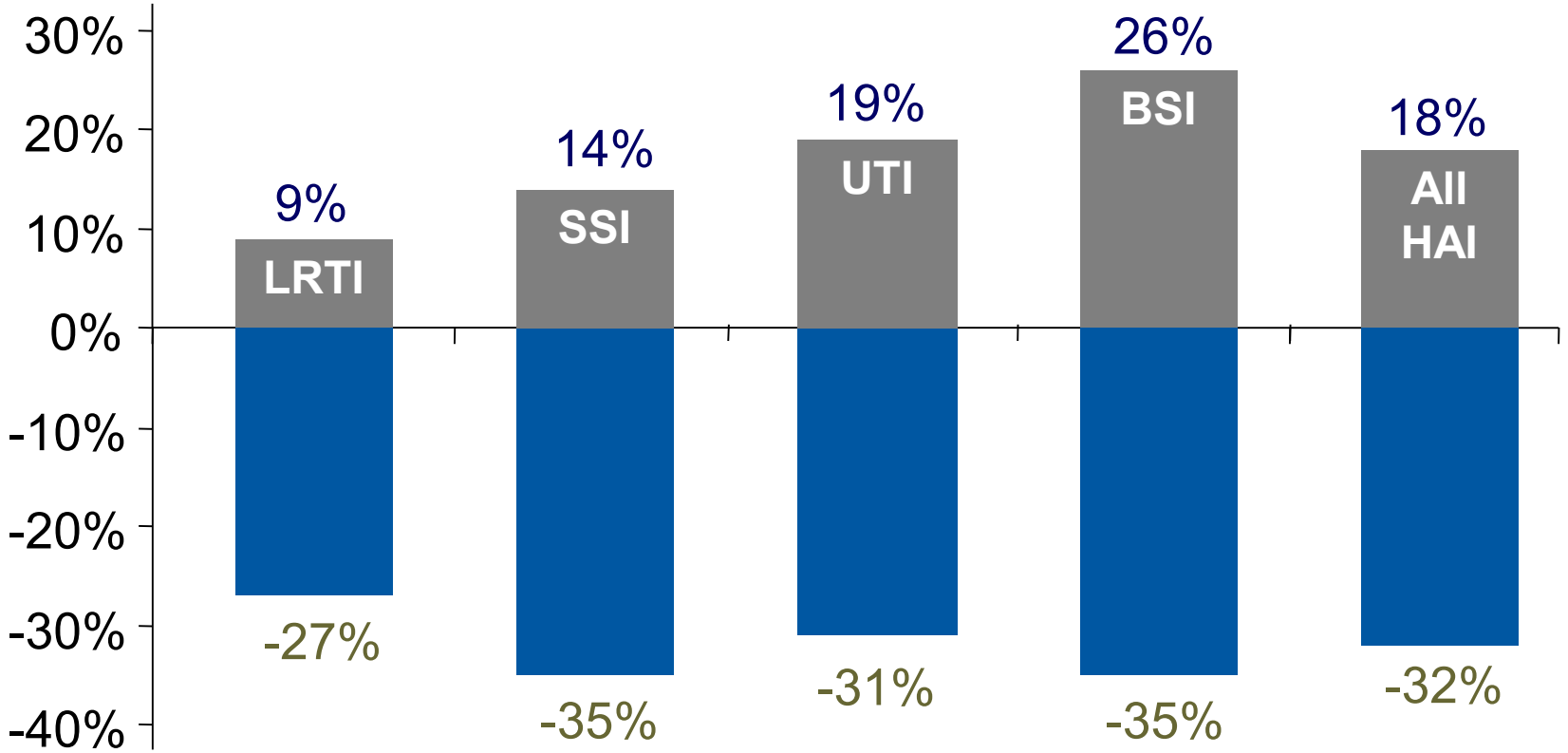
Site of infection	Patient group	Quality of ISCP*							
		Very effective		Moderately effective		Ineffective		All hospitals	
		% change	Z value†	% change	Z value†	% change	Z value†	% change	Z value†
Surgical wound infection	High risk	−48.0	−3.08	−4.8	−0.63	13.8	2.09	−0.6	−0.11
	Low risk	−23.6	−2.28	20.4	2.48	21.3	4.15	18.9	4.51
Urinary tract infection	High risk	−35.8	−4.51			18.5	3.84	13.8	3.04
	Low risk	−41.6	−2.58			30.7	6.89	27.0	6.19
Pneumonia	High risk (surgical)	−7.3	−0.50			9.3	2.07	8.0	1.85
	Low risk (medical)			−7.7	−1.47	10.0	1.84	1.2	0.32
Bacteremia	All patients	−27.6	−2.40	18.6	2.24	25.5	5.20	21.6	5.07

* Defined in tables 1–4.

† Test of the null hypothesis that the percentage change was 0; $Z > 1.64$ or $Z < -1.64$ is statistically significant in one-tailed test at the $p = 0.05$ level.

Haley RW *J Epidemiol* 1985;121:182

Ohne Infektionsüberwachung und -Prävention



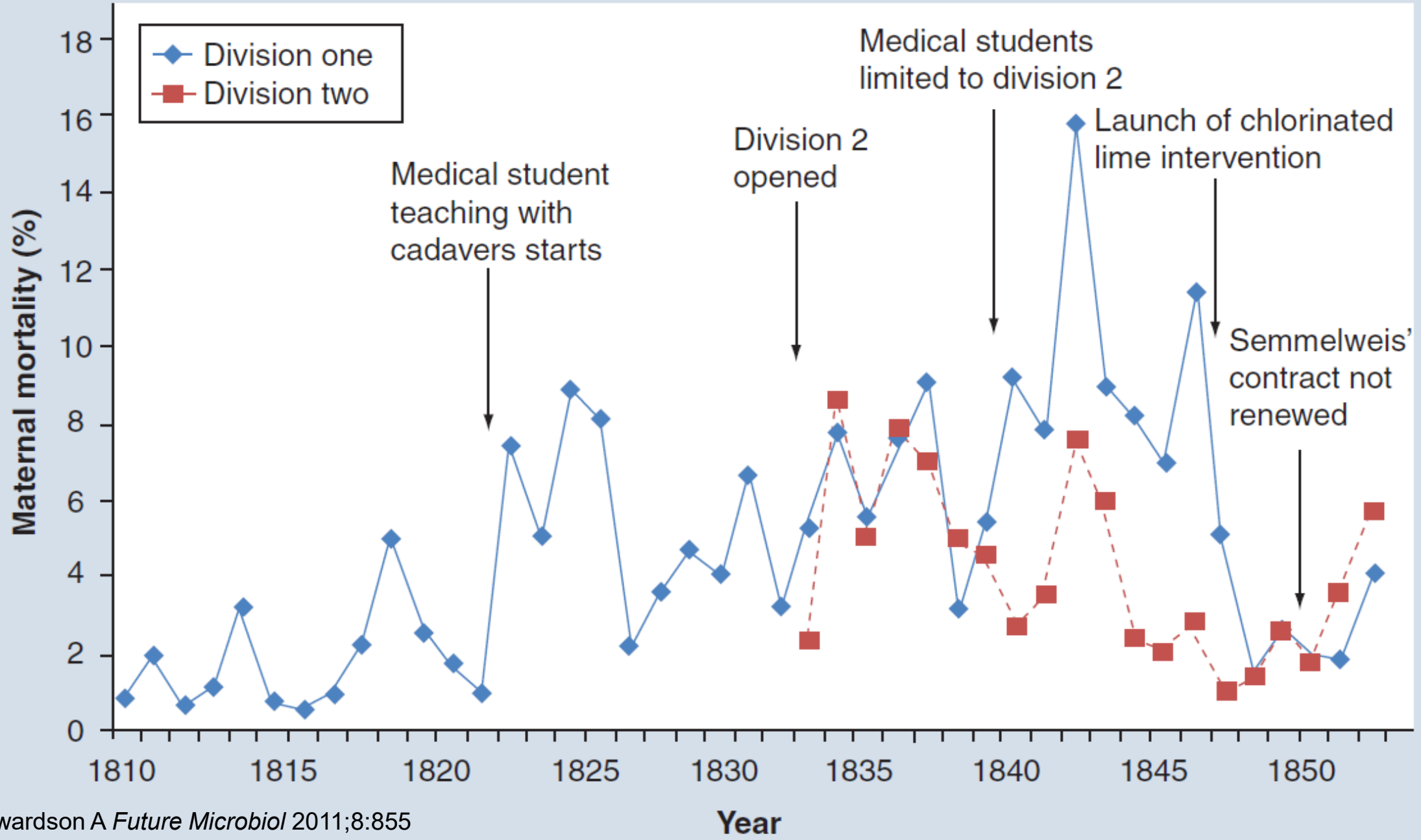
Mit Infektionsüberwachung und -Prävention

338 zufällig ausgewählte Spitäler aus dem «*SENIC Universe of hospitals*»

	1970	**1975/1976**
	169’518 Patienten	169’526 Patienten
	1’782’172 Patiententage	1’603’307 Patiententage

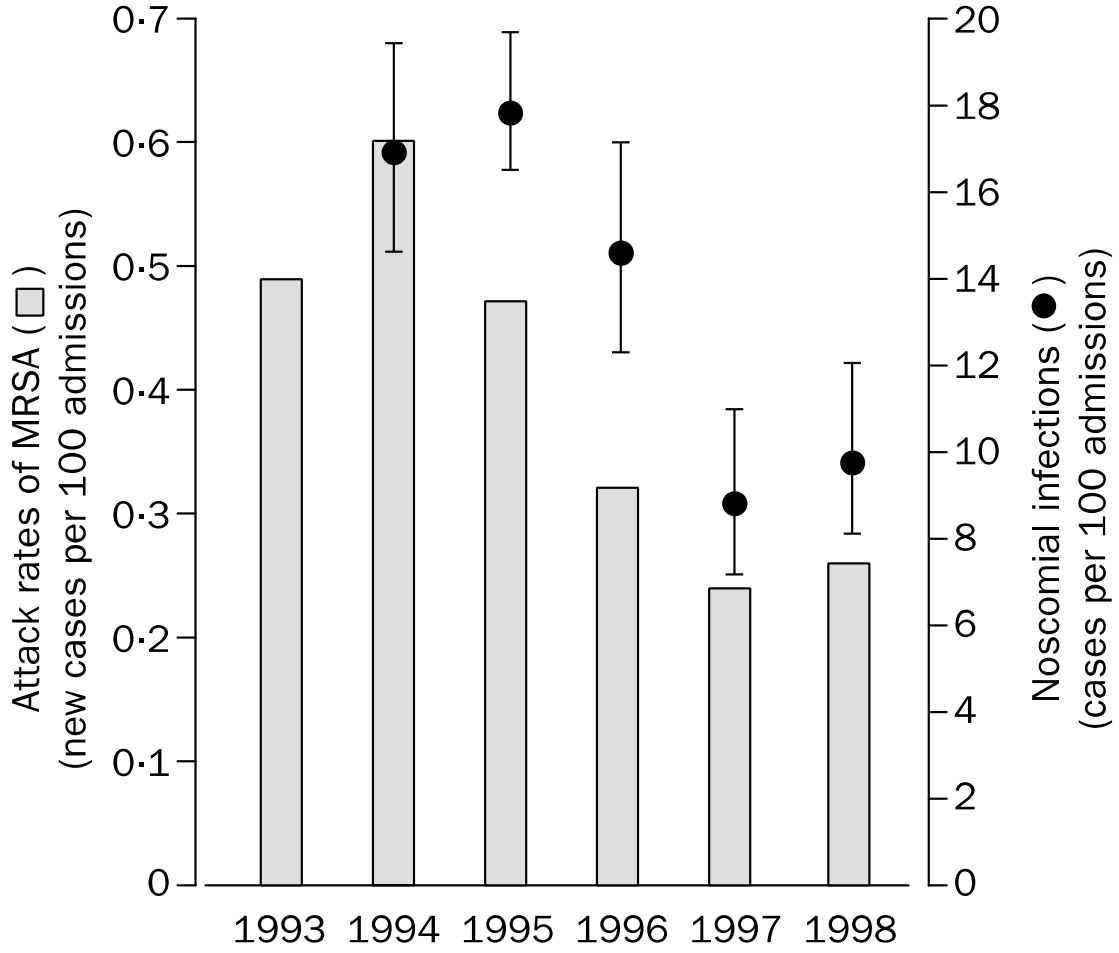
Haley RW *J Epidemiol* 1985;121:182

Die “*SAVE LIVES: Clean Your Hands*” Kampagne



Stewardson A *Future Microbiol* 2011;8:855

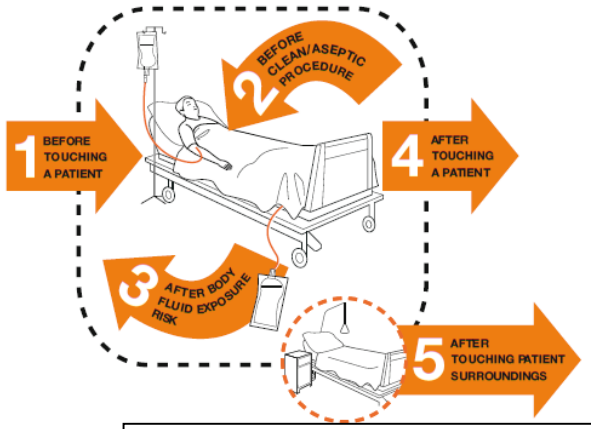
Händehygiene schafft es ins Lancet!



Pittet D *Lancet* 2000;56:1307

When?

YOUR 5 MOMENTS FOR HAND HYGIENE



How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

Apply a palmful of the product in a cupped hand, covering all surfaces;

Rub hands palm to palm;

Right palm over left dorsum with interlaced fingers and vice versa;

Clean hands are safer hands.

Are yours clean?

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

Wet hands with water;

Apply enough soap to cover all hand surfaces;

Rub hands palm to palm;

Right palm over left dorsum with interlaced fingers and vice versa;

Palm to palm with fingers interlaced;

Backs of fingers to opposing palms with fingers interlocked;

Rotational rubbing of left thumb clasped in right palm and vice versa;

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

Rinse hands with water;

Dry hands thoroughly with a single use towel;

Use towel to turn off faucet;

Your hands are now safe.

World Health Organization

WHO Guidelines on Hand Hygien

First Global Patie
Clean Care is Sa

SAVE LIVES
Clean Your Hands

Hand Hygie
Technical F

To be used by healt
trainers and observ

1 BEFORE TOUCHING A PATIENT

World Heal
Organizati

World Health Organization

Hand Hygiene: Wh

WHY?

- Thousands of people die
around the world from infe
acquired while receiving h
- Hands are the main pathw
germ transmission during
- Hand hygiene is therefore
important measure to av
transmission of harmful g
and prevent health care-
infections.
- This brochure explains h
when to practice hand h

WHO?

- Any health-care worker
person involved in direc
patient care needs to b
about hand hygiene an
able to perform it corre
the right time.

PAGE 1 OF 7

WHO acknowledges the Hôpitaux Universitaires de G
of the Infection Control Programme, for their active p

Revised August 2009

World Health Organization | Patient Safety
A World Alliance for Safer Health Care | SAVE LIVES Clean Your Hands

Glove Use Information Leaflet

Outline of the evidence and considerations on medical glove use to prevent germ transmission

Definitions

Medical gloves are defined as disposable gloves used during medical procedures; they include:

1. Examination gloves (non sterile or sterile)
2. Surgical gloves that have specific characteristics of thickness, elasticity and strength and are sterile
3. Chemotherapy gloves – these gloves are not addressed within this document

Rationale for using medical gloves:

Medical gloves are recommended to be worn for two main reasons:

1. To reduce the risk of contamination of health-care workers hands with blood and other body fluids.
2. To reduce the risk of germ dissemination to the environment and of transmission from the health-care worker to the patient and vice versa, as well as from one patient to another.

Gloves should therefore be used during all patient-care activities that may involve exposure to blood and all other body fluid (including contact with mucous membrane and non-intact skin), during contact precautions and outbreak situations.

The efficacy of gloves in preventing contamination of health-care workers' hands and helping to reduce transmission of pathogens in health care has been confirmed in several clinical studies. Nevertheless, health-care workers should be informed that gloves do not provide complete protection against hand contamination. Pathogens may gain access to the caregivers' hands via small defects in gloves or by contamination of the hands during glove removal. Hand hygiene by rubbing or washing remains the basic to guarantee hand decontamination after glove removal.

Key learning point: gloves do not provide complete protection against hand contamination.

The impact of wearing gloves on adherence to hand hygiene policies has not been definitively established, since published studies have yielded contradictory results. However, the recommendation to wear gloves during an entire episode of care for a patient who requires contact precautions, without considering indications for their removal, such as an indication for hand hygiene, could actually lead to the transmission of germs.

Key learning point: prolonged use of gloves for contact precautions in the absence of considering the need to perform hand hygiene can result in the transmission of germs.

Glove use and the need for hand hygiene:

- When an indication for hand hygiene precedes a contact that also requires glove usage, hand rubbing or hand washing should be performed ***before donning gloves***.
- When an indication for hand hygiene follows a contact that has required gloves, hand rubbing or hand washing should occur ***after removing gloves***.
- When an indication for hand hygiene applies while the health-care worker is wearing gloves, then gloves should be ***removed to perform handrubbing or handwashing***.

Inappropriate glove use:

- The use of gloves when not indicated represents a waste of resources and does not contribute to a reduction of cross-transmission.
- It may also result in missed opportunities for hand hygiene.
- The use of contaminated gloves caused by inappropriate storage, inappropriate moments and techniques for donning and removing, may also result in germ transmission.

Key learning point: it is important that health-care workers are able to differentiate between specific clinical situations when gloves should be worn and changed and those where their use is not required (see figure The Glove Pyramid). Moreover, the health-care worker should be accurately informed on the moment (see Table) for donning and removing gloves.

PAGE 1 OF 4

Revised August 2009

SAVE LIVES
Clean Your Hands

Guide to Im

A Guide to the Implen
Multimodal Hand Hy

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The Hand Hy

WHO Guidel

Guide to Implementation

Tools for System Change	Tools for Tr Educat
Ward Infrastructure Survey	Slides for t Hygiene Co
Alcohol-based Handrub Planning and Costing Tool	Slides for Sessions t Obser Health-C
Guide to Local Production: WHO-recommended Handrub Formulations	Hand Train
Soap / Handrub Consumption Survey	Slides A the Tr
Protocol for Evaluation of Tolerability and Acceptability of Alcohol-based Handrub in Use or Planned to be Introduced: Method 1	Hand H Refe
Protocol for Evaluation and Comparison of Tolerability and Acceptability of Different Alcohol-based Handrubs: Method 2	Obs

World Health Organization

SAVE LIVES
Clean Your Hands

Hand Hygiene Self-Assessment Framework 2010

Introduction and user instructions

The Hand Hygiene Self-Assessment Framework is a systematic tool with which to obtain a situation analysis of hand hygiene promotion and practices within an individual health-care facility.

What is its purpose?

While providing an opportunity to reflect on existing resources and achievements, the Hand Hygiene Self-Assessment Framework also helps to focus on future plans and challenges. In particular, it acts as a diagnostic tool, identifying key issues requiring attention and improvement. The results can be used to facilitate development of an action plan for the facility's hand hygiene promotion programme. Repeated use of the Hand Hygiene Self-Assessment Framework will also allow documentation of progress with time.

Overall, this tool should be a catalyst for implementing and sustaining a comprehensive hand hygiene programme within a health-care facility.

Who should use the Hand Hygiene Self-Assessment Framework?

This tool should be used by professionals in charge of implementing a strategy to improve hand hygiene within a health-care facility. If no strategy is being implemented yet, then it can also be used by professionals in charge of infection control or senior managers at the facility directorate. The framework can be used globally, by health-care facilities at any level of progress as far as hand hygiene promotion is concerned.

How is it structured?

The Hand Hygiene Self-Assessment Framework is divided into five components and 27 indicators. The five components reflect the five elements of the WHO Multimodal Hand Hygiene Improvement Strategy (http://www.who.int/gpsc/5may/tools/en/index.html) and the indicators have been selected to represent the key elements of each component. These indicators are based on evidence and expert consensus and have been framed as questions with defined answers (either "Yes/No" or multiple options) to facilitate self-assessment. Based on the score achieved for the five components, the facility is assigned to one of four levels of hand hygiene promotion and practice: Inadequate, Basic, Intermediate and Advanced.

Inadequate: hand hygiene practices and hand hygiene promotion are deficient. Significant improvement is required.

Basic: some measures are in place, but not to a satisfactory standard. Further improvement is required.

Intermediate: an appropriate hand hygiene promotion strategy is in place and hand hygiene practices have improved. It is now crucial to develop long-term plans to ensure that improvement is sustained and progresses.

Advanced: hand hygiene promotion and optimal hand hygiene practices have been sustained and/or improved, helping to embed a culture of safety in the health-care setting.

Leadership criteria have also been identified to recognise facilities that are considered a reference centre and contribute to the promotion of hand hygiene through research, innovation and information sharing. The assessment according to leadership criteria should only be undertaken by facilities having reached the Advanced level.

How does it work?

While completing each component of the Hand Hygiene Self-Assessment Framework, you should circle or highlight the answer appropriate to your facility for each question. Each answer is associated with a score. After completing a component, add up the scores for the answers you have selected to give a subtotal for that component. During the interpretation process these subtotals are then added up to calculate the overall score to identify the hand hygiene level to which your health-care facility is assigned.

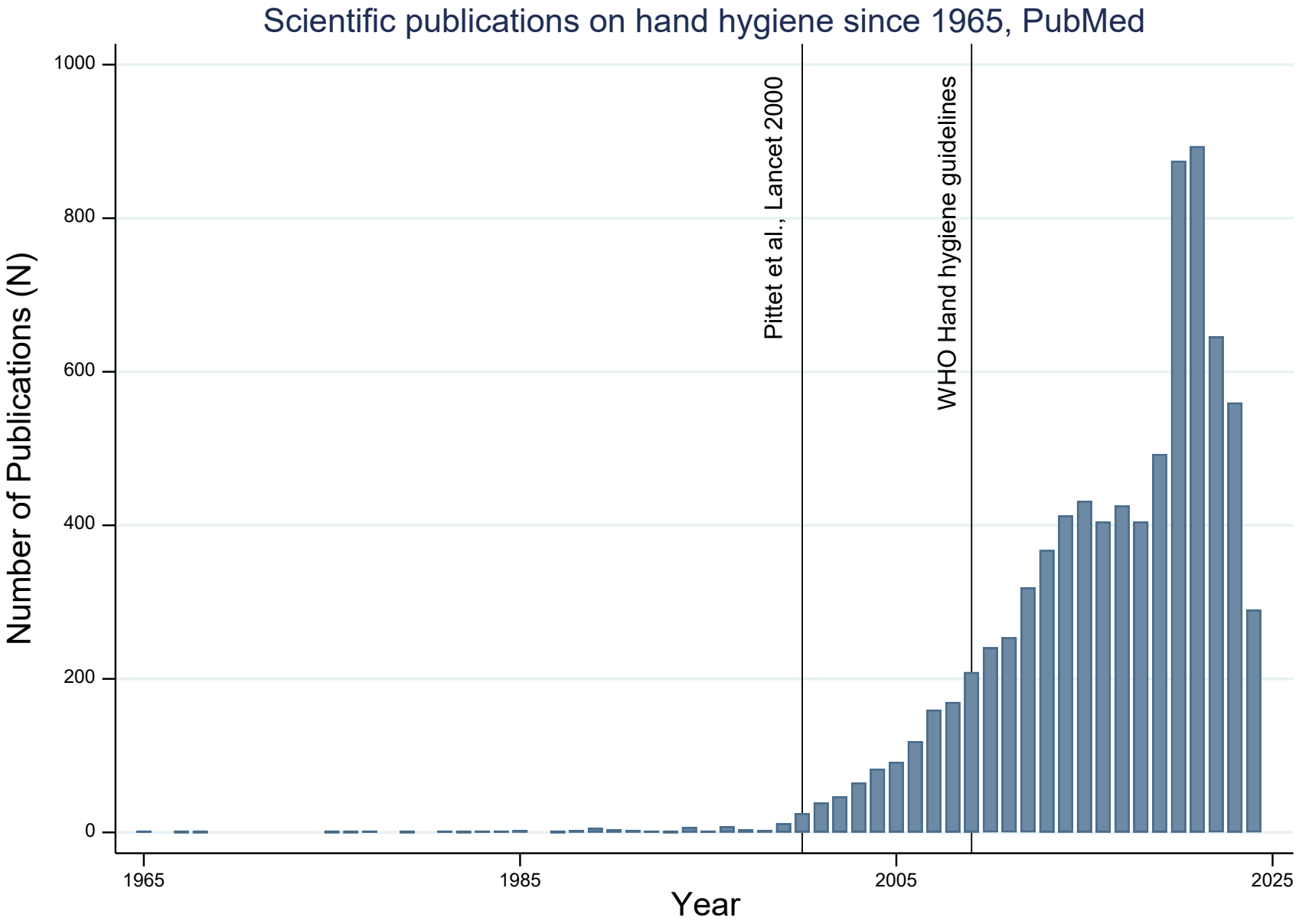
The assessment should not take more than 30 minutes, provided that the information is easily available.

Within the Framework you will find a column called "WHO implementation tools" listing the tools made available from the WHO First Global Patient Safety Challenge to facilitate the implementation of the WHO Multimodal Hand Hygiene Improvement Strategy (http://www.who.int/gpsc/5may/tools/en/index.html). These tools are listed in relation to the relevant indicators included in the Framework and may be useful when developing an action plan to address areas identified as needing improvement.

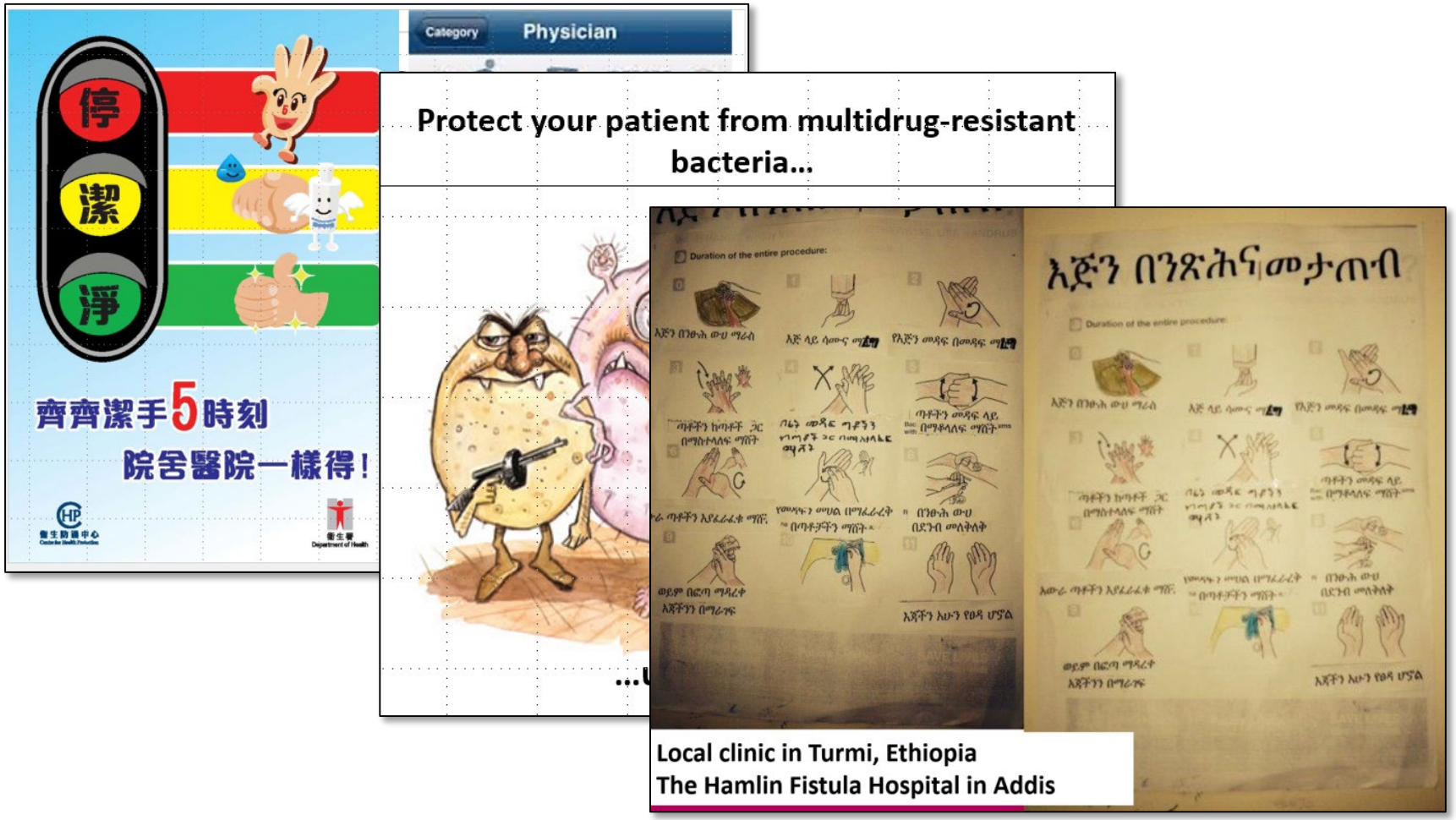
Is the Hand Hygiene Self-Assessment Framework suitable for inter-facility comparison?

Health-care facilities or national bodies may consider adopting this tool for external comparison or benchmarking. However, this was not a primary aim during the development of this tool. In particular, we would draw attention to the risks inherent in using a self-reported evaluation tool for external benchmarking and also advise the use of caution if comparing facilities of different sizes and complexity, in different socioeconomic settings. It would be essential to consider these limitations if inter-facility comparison is to be undertaken.

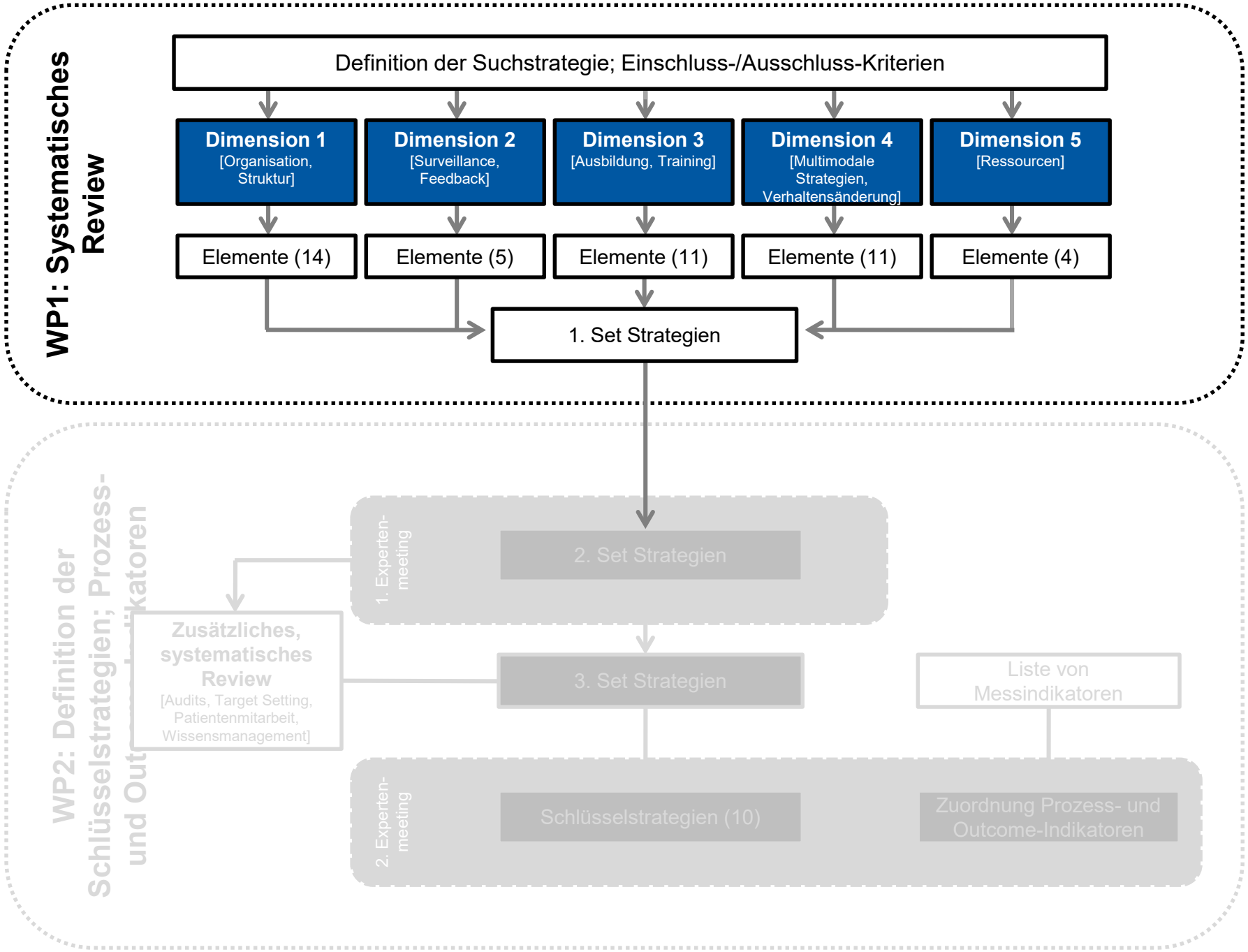
WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

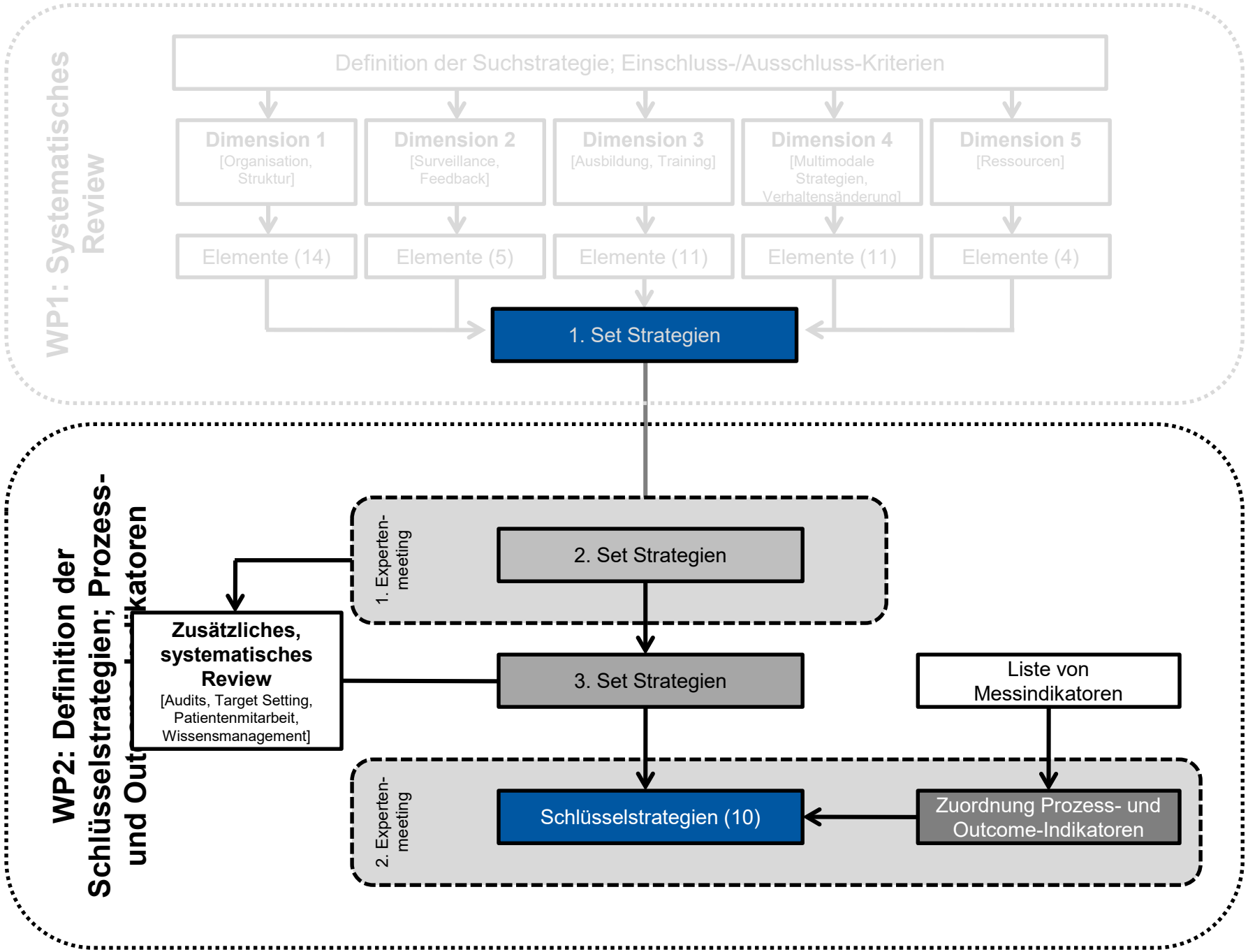

Scientific publications on hand hygiene since 1965, PubMed
Number of Publications (N)
1000
800
600
400
200
0
Pittet et al., Lancet 2000
WHO Hand hygiene guidelines
1965
1985
2005
2025
Year

Händehygiene wird global



Von «SIGHT» zu «IPCAF»


WP1: Systematisches Review
Definition der Suchstrategie; Einschluss-/Ausschluss-Kriterien
Dimension 1 [Organisation, Struktur]
Dimension 2 [Surveillance, Feedback]
Dimension 3 [Ausbildung, Training]
Dimension 4 [Multimodale Strategien, Verhaltensänderung]
Dimension 5 [Ressourcen]
Elemente (14)
Elemente (5)
Elemente (11)
Elemente (11)
Elemente (4)
1. Set Strategien
WP2: Definition der Schlüsselstrategien; Prozess- und Outcome-Indikatoren
1. Experten-meeting
2. Set Strategien
Zusätzliches, systematisches Review
[Audits, Target Setting, Patientenmitarbeit, Wissensmanagement]
3. Set Strategien
Liste von Messindikatoren
2. Experten-meeting
Schlüsselstrategien (10)
Zuordnung Prozess- und Outcome-Indikatoren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Schlüsselstrategien (10)
Zuordnung Prozess- und Outcome-Indikatoren

Organisation Spitalhygiene/Infektionsprävention

Schlüsselstrategie

Ein erfolgreiches **Präventionsprogramm** umfasst: eine **Hygiene-Pflegefachkraft** ≤ 250 Betten; einen **Hygienefacharzt/eine Hygienefachärztin**; **mikrobiologische Unterstützung**; Unterstützung des **Spitalmanagements**

Auslastung, Arbeitsbelastung

Schlüsselstrategie

Die **Auslastung** einer Abteilung sollte der geplanten entsprechen und diese nicht übersteigen; Beschäftigung und **Arbeitsbelastung** von Pflegenden und Ärzten/Ärztinnen sollte der zu erwartenden Pflegeleistung angepasst sein; die Zahl von **Aushilfspersonal** soll auf ein Minimum beschränkt werden

Material, Arbeitsergonomie

Schlüsselstrategie

Material soll in genügender **Qualität** und **Menge** vorhanden sein und ergonomisches Arbeiten unterstützen

Anwendung von Guidelines und Richtlinien

Schlüsselstrategie

Guidelines sollen **zugänglich** sein und in die **Weiterbildung** eingebaut werden

Team- und anwendungsorientiertes Lernen

Schlüsselstrategie

Mitarbeiter, welche ein Projekt ausführen sollen, müssen in die Ausbildung und Weiterbildung **eingebunden** werden; Inhalte von Ausbildungen sollen **Team- und Anwendungsorientiert** sein

Standardisierte Audits

Schlüsselstrategie

Audits mit **standardisierter** (messbarer) und systematischer **Beurteilung** von (Arbeits-/Pflege-) Prozessen mit zeitnahem **Feedback**

Überwachung von Prozess- und Outcomeindikatoren

Schlüsselstrategie

Teilnahme an einer prospektiven **Surveillance** von Prozessen und/oder Infektionen, am Besten innerhalb eines **Netzwerkes** welches ein Benchmarking erlaubt

Multimodale Strategien zur Infektionsprävention

Schlüsselstrategie

Die Umsetzung von **Infektionspräventions-Programmen** erfolgt mittels einer multimodale Strategie, die durch multidisziplinäre Gruppen erarbeitet wurde und die lokalen Gegebenheiten in Betracht zieht

Champions und Vorbilder

Schlüsselstrategie

Champions* sollen **identifiziert** und in die Umsetzung von Projekten **eingebunden** werden

*Rollenmodelle, Vorbilder

Organisationskultur

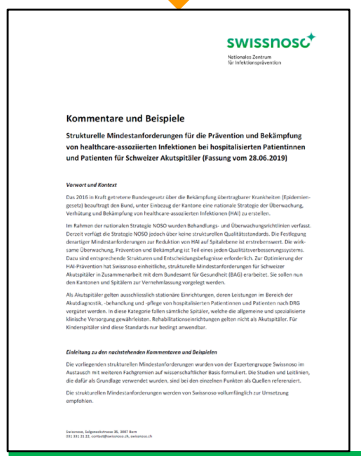
Schlüsselstrategie

Eine positive Unternehmenskultur, welche die **Kommunikation** und die **Arbeitsbeziehungen** zwischen Mitarbeitern und Abteilungen aktiv unterstützt

Key components (ECDC – SIGHT)	Core components (WHO)
An effective infection control programme in an acute care hospital must include at least: one full-time specifically trained IC-nurse ≤ 250 beds; a dedicated physician trained infection control; microbiological support; data management support	An IPC programme with a dedicated, trained team should be in place in each acute health care facility for the purpose of preventing HAI and combating AMR through IPC good practices
To make sure that the ward occupancy does not exceed the capacity for which it is designed and staffed; staffing and workload of frontline health-care workers must be adapted to acuity of care; and the number of pool/agency nurses and physicians minimized	In order to reduce the risk of HAI and the spread of AMR, the following should be addressed: (1) bed occupancy should not exceed the standard capacity of the facility; (2) health care worker staffing levels should be adequately assigned according to patient workload
Sufficient availability of and easy access to material and equipment and optimized ergonomics	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
Use of guidelines in combination with practical education and training	Evidence-based guidelines should be developed and implemented for the purpose of reducing HAI and AMR. Education and training of the relevant health care workers on guideline recommendations and monitoring of adherence with guideline recommendations should be undertaken to achieve successful implementation
Education and training involves frontline staff, and is team- and task-oriented	At the 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
Organizing audits as a standardized (scored) and systematic review of practice with timely feedback	Regular monitoring/audit and timely feedback of health care practices should be undertaken according to IPC standards to prevent and control HAIs and AMR at the health care facility level. Feedback should be provided to all audited persons and relevant staff
Participating in prospective surveillance and offering active feedback, preferably as part of a network	Facility-based HAI surveillance should be performed to guide IPC interventions and detect outbreaks, including AMR surveillance with timely feedback of results to health care workers and stakeholders and through national networks
Implementing infection control programmes follow a multimodal strategy including tools such as bundles and checklists developed by multidisciplinary teams and taking into account local conditions	At the facility level, IPC activities should be implemented using multimodal strategies to improve practices and reduce HAI and AMR
Identifying and engaging champions in the promotion of a multimodal intervention strategy	
A positive organizational culture by fostering working relationships and communication across units and staff groups	

Zingg W *Lancet Infect Dis* 2015; 15: 212
Storr J *Antimicrob Resist Infect Control* 2017; 6: 6

https://www.who.int/teams/integrated-health-services/infection-prev ents


swissnoso
Nationales Zentrum für Infektionsprävention

Kommentare und Beispiele

Strukturelle Mindestanforderungen für die Prävention und Bekämpfung von healthcare-assoziierten Infektionen bei hospitalisierten Patientinnen und Patienten für Schweizer Akutspitäler (Fassung vom 28.06.2019)

Verwort und Kontext

Das 2016 in Kraft getretene Bundesgesetz über die Bekämpfung übertragbarer Krankheiten (Epidemiengesetz) beauftragt den Bund, unter Einbezug der Kantone eine nationale Strategie der Überwachung, Verhütung und Bekämpfung von healthcare-assoziierten Infektionen (HAI) zu erstellen.

Im Rahmen der nationalen Strategie NOSO wurden Behandlungs- und Überwachungsrichtlinien verfasst. Derzeit verfügt die Strategie NOSO jedoch über keine strukturellen Qualitätsstandards. Die Festlegung derartiger Mindestanforderungen zur Reduktion von HAI auf Spitalebene ist entscheidend. Die wirksame Überwachung, Prävention und Bekämpfung ist Teil eines jeden Qualitätsverbesserungssystems. Dazu sind entsprechende Strukturen und Entscheidungsbefugnisse erforderlich. Zur Optimierung der HAI-Prävention hat Swissnoso evidenzbasierte, strukturelle Mindestanforderungen für Schweizer Akutspitäler in Zusammenarbeit mit dem Bundesamt für Gesundheit (BAG) erarbeitet. Sie sollen nun den Kantonen und Spitälern zur Vernehmlassung vorgelegt werden.

Als Akutspitäler gelten ausschliesslich stationäre Einrichtungen, deren Leistungen im Bereich der Akutdiagnostik, -behandlung und -pflege von hospitalisierten Patientinnen und Patienten nach DRG vergütet werden. In diese Kategorie fallen sämtliche Spitäler, welche die allgemeine und spezialisierte klinische Versorgung gewährleisten. Rehabilitationseinrichtungen gelten nicht als Akutspitäler. Für Kinderspitäler sind diese Standards nur bedingt anwendbar.

Einleitung zu den nachstehenden Kommentaren und Beispielen

Die vorliegenden strukturellen Mindestanforderungen wurden von der Expertengruppe Swissnoso im Austausch mit weiteren Fachgremien auf wissenschaftlicher Basis formuliert. Die Studien und Leitlinien, die dafür als Grundlage verwendet wurden, sind bei den einzelnen Punkten als Quellen referenziert.

Die strukturellen Mindestanforderungen werden von Swissnoso vollumfänglich zur Umsetzung empfohlen.

Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Eidgenössisches Departement des Innern EDI
Bundesamt für Gesundheit BAG

C GDK S — Konferenz der kantonalen Gesundheitsdirektorinnen und -direktoren
Conférence des directrices et directeurs cantonaux de la santé
Conferenza delle direttrici e dei direttori cantonali della sanità

H+ DIE SPITÄLER DER SCHWEIZ
LES HÔPITAUX DE SUISSE

VKS / AMCS — Vereinigung der Kantonsärztinnen und Kantonsärzte der Schweiz
Association des médecins cantonaux de Suisse
Associazione dei medici cantonali della Svizzera
Associaziun dals medis cantunals da la Svizra
Swiss Association of Cantonal Officers of Health

Schweizerische Gesellschaft für Infektiologie
Swiss Society for Infectious Diseases
Société Suisse d'Infectiologie

Schweizerische Gesellschaft für Spitalhygiene

fibs — Fachexpertenforum für Infektionsprävention & Beratern in für Spitalhygiene

SIPI — SPECIALISTES INFIRMIERS PRÉVENTION DE L'INFECTION

PIGS — Pediatric Infectious Disease Group of Switzerland

Stakeholder-Konsultationen

Strategie NOSO

Gemeinsam gegen Infektionen in Spitälern und Pflegeheimen
www.strategie-noso.ch/de

Strukturelle Mindestanforderungen

für die Prävention und Bekämpfung von healthcare-assoziierten Infektionen (HAI) bei hospitalisierten Patientinnen und Patienten für Schweizer Akutspitäler

Version 1.0, 30. September 2020

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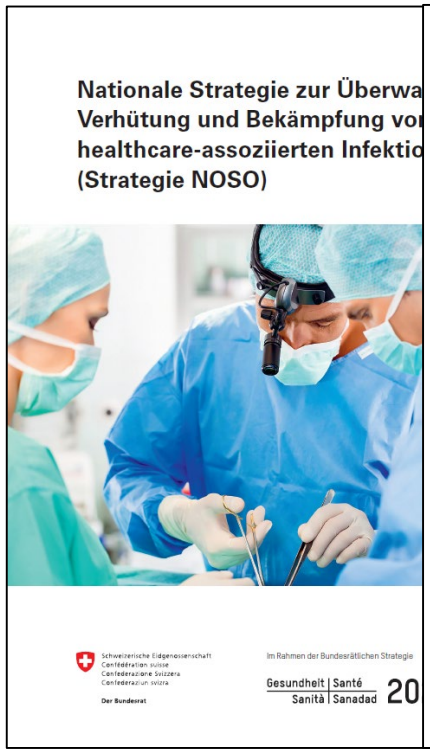
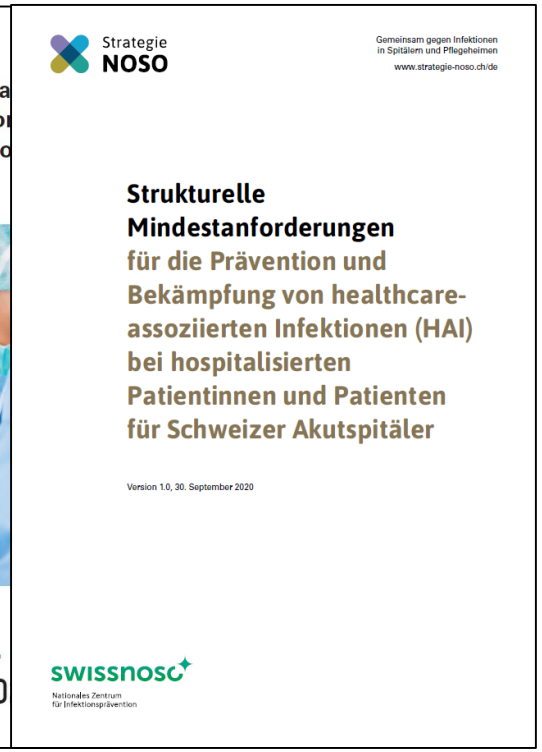
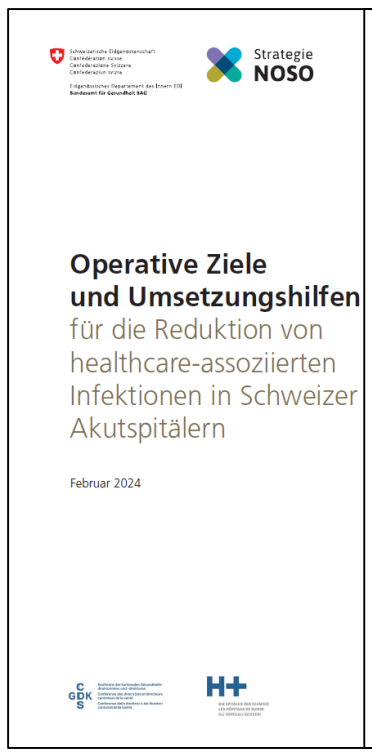
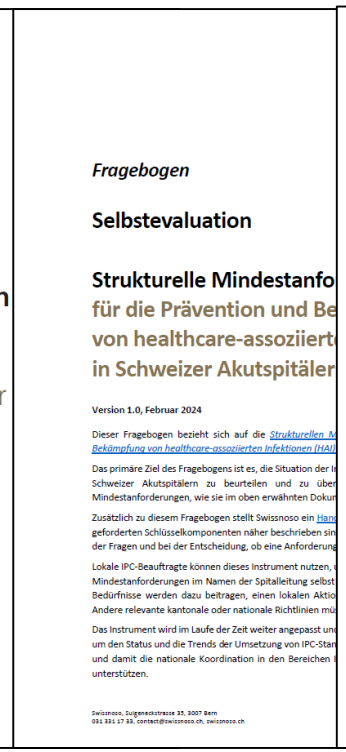
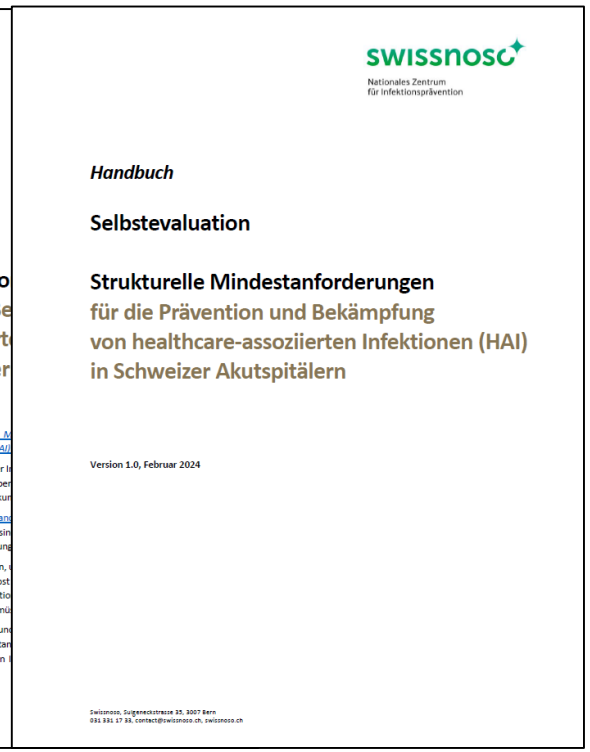
für Infektionsprävention



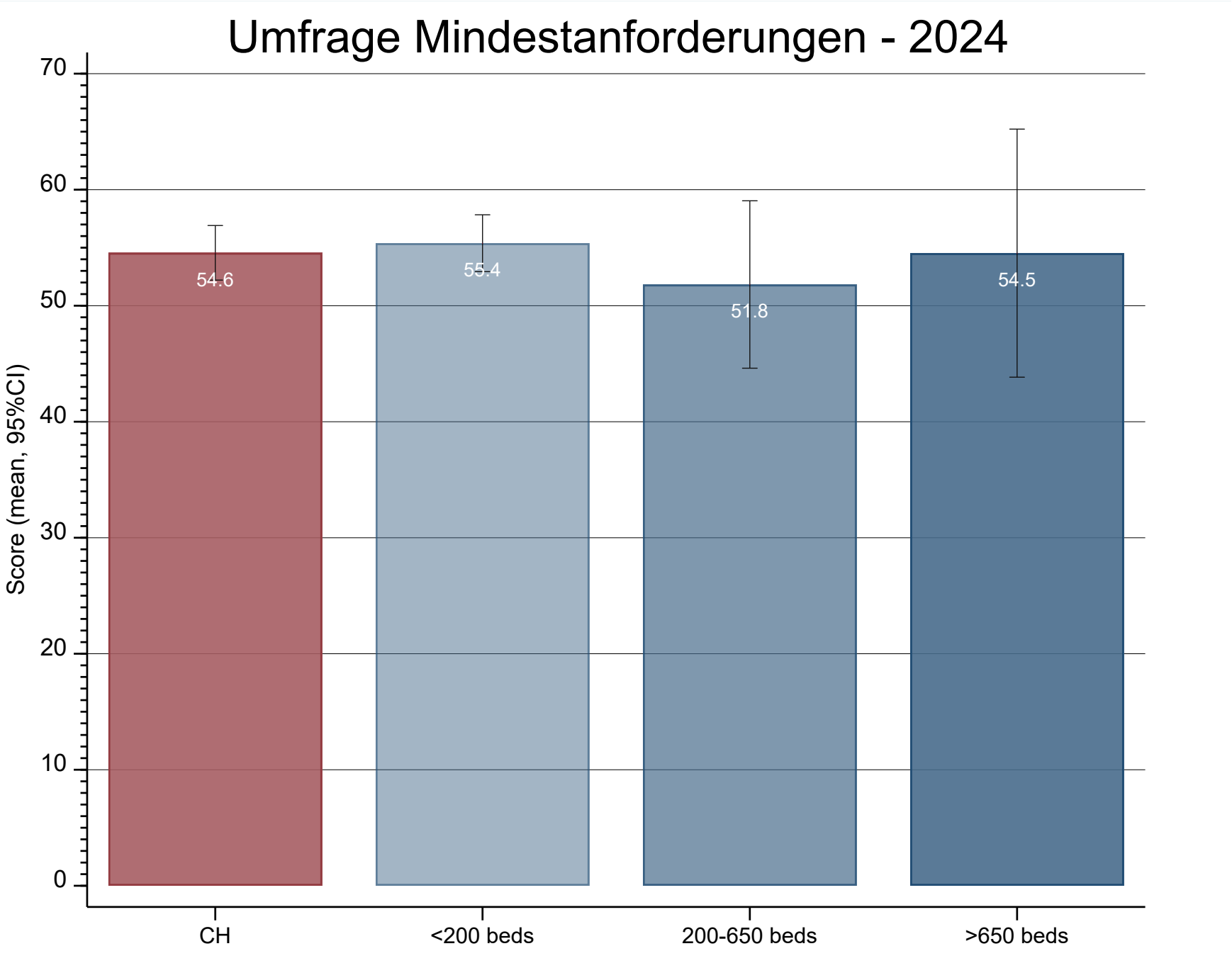




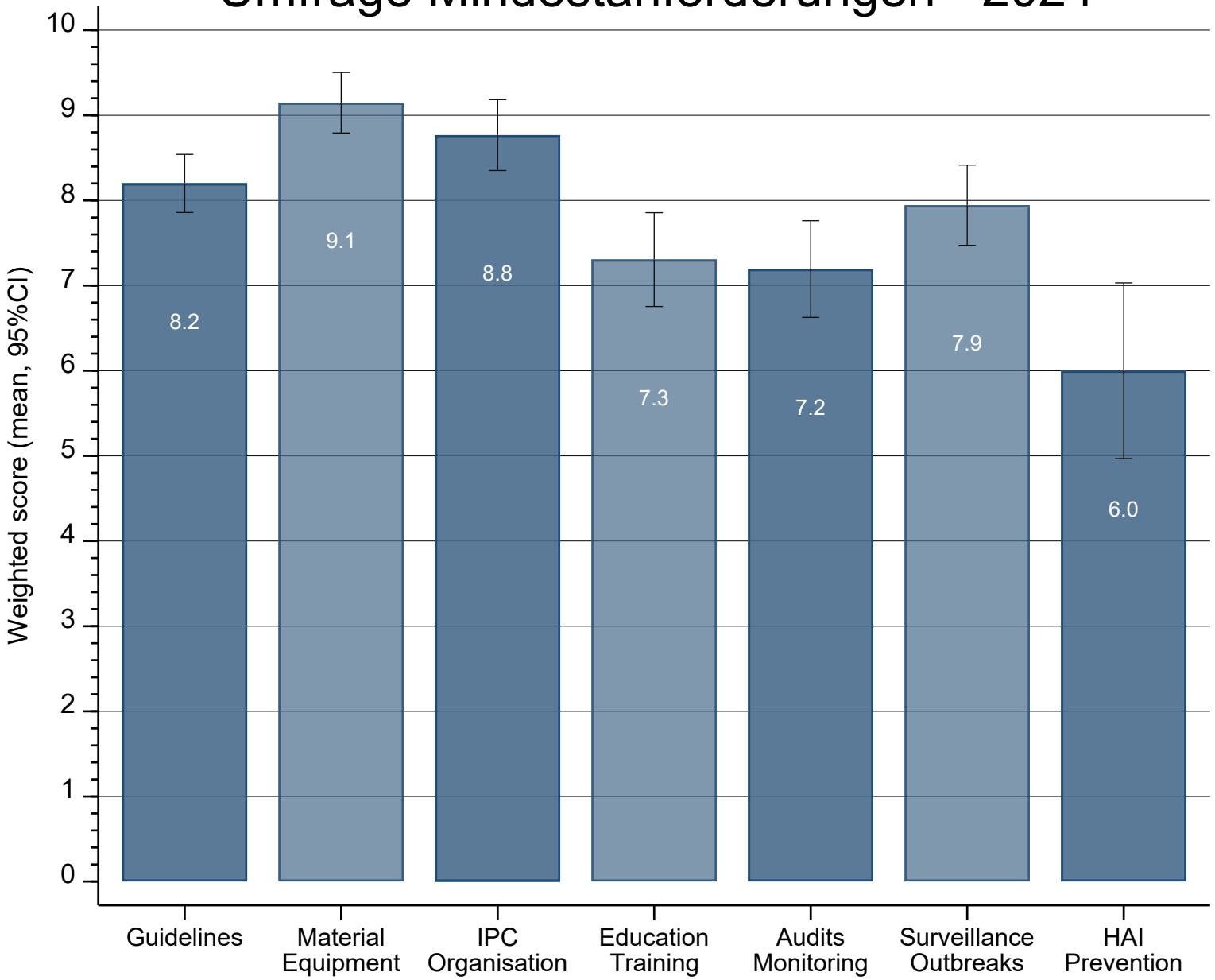




2016 2020 2024 2024 2024

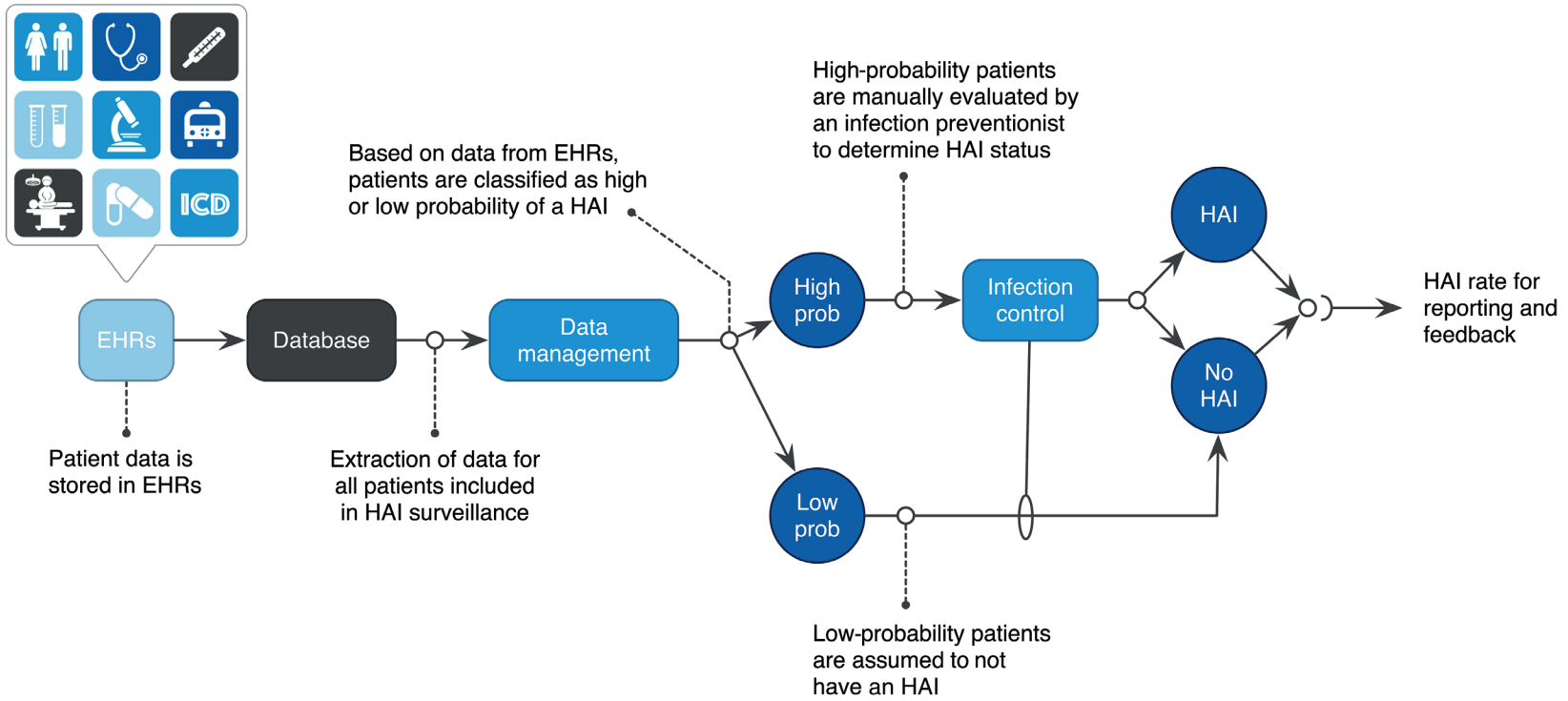

Umfrage Mindestanforderungen - 2024
Score (mean, 95%CI)
70
60
50
40
30
20
10
0
54.6
55.4
51.8
54.5
CH
<200 beds
200-650 beds
>650 beds

Umfrage Mindestanforderungen - 2024

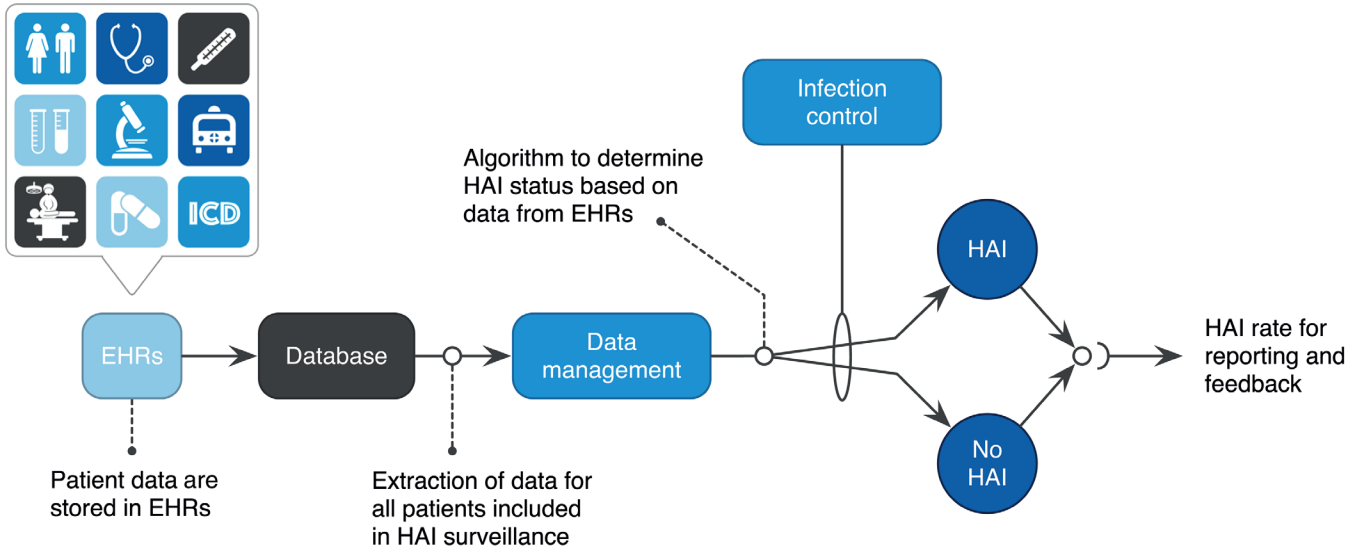


HAI: healthcare-associated infection

Visionen

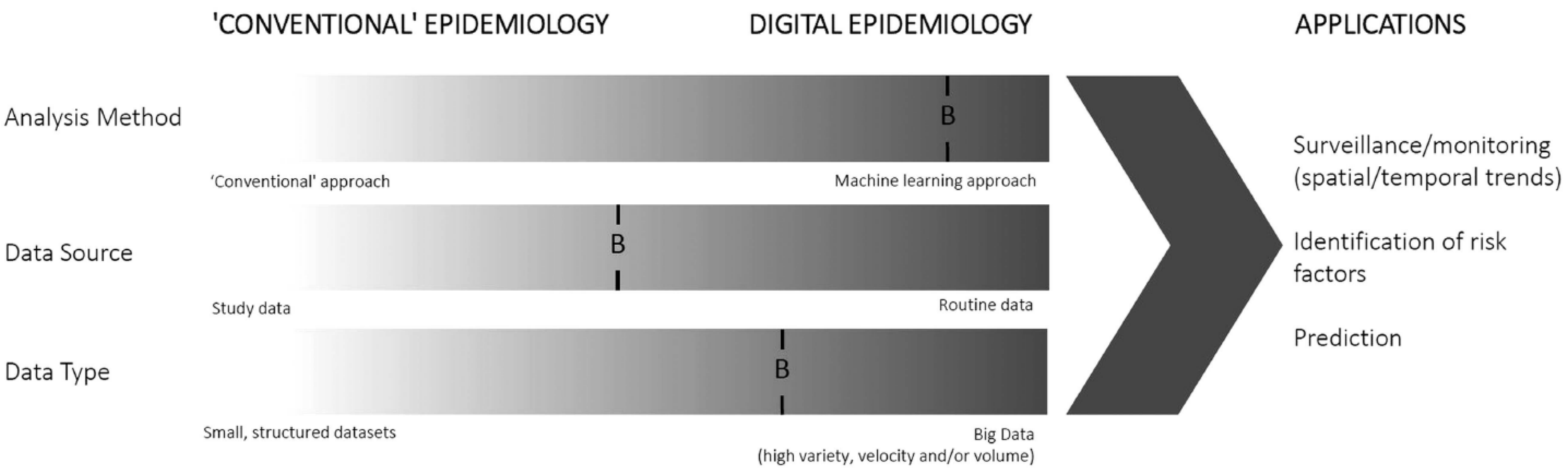


+ Smartphone Applikationen zur Überwachung nach Spitalaustritt



Van Mourik MSM *Clin Infect Dis* 2018;66:970

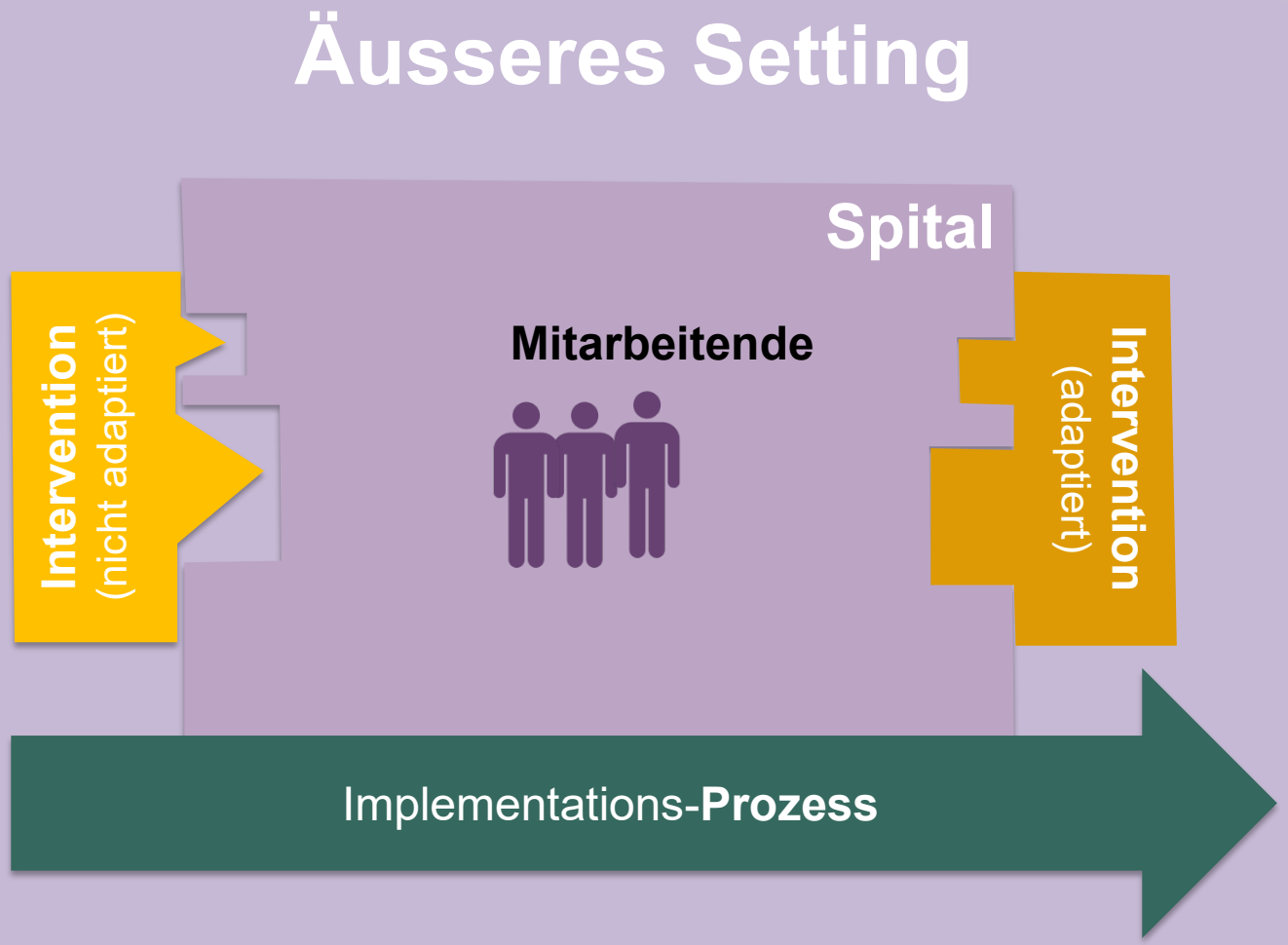
Modelling, Machine Learning



Fiktives Projekt «B», das sich je nach Konzept in den drei Achsen unterschiedlich positioniert

Roth JA *Infect Control Hosp Epidemiol* 2018;39:1457

Implementierungswissenschaft als Kernkompetenz



Damschroder L *Implementation Sci* 2009;4:50

Patientensicherheit und Prävention müssen Teil der DNA im medizinischen Alltag werden

Bis es soweit ist, brauchen wir Surveillance und Präventionsprojekte…

…das wussten schon die Leute von SENIC!

SGInf/SGSH/SSM – Jahreskonferenz 2024, Bern

Infektionsprävention mehr als 50 Jahre

Meilensteine und Visionen

Vielen Dank für Ihre Aufmerksamkeit

Walter Zingg

Klinik für Infektionskrankheiten und Spitalhygiene, Universitätsspital Zürich

USZ Universitäts Spital Zürich