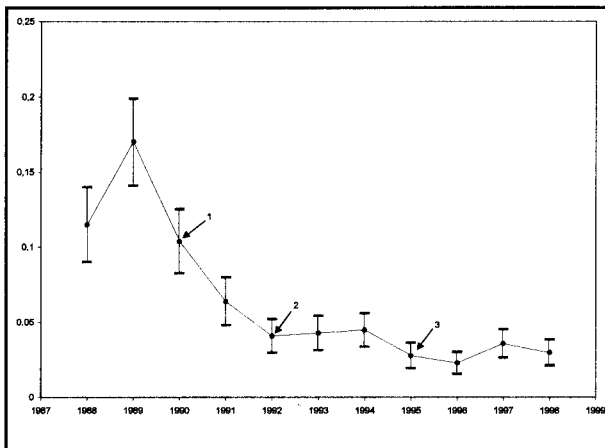


FIGURE. Trends in surgical-site infection rates. (1.) Start of the program. In 1989, with the start of the Active Epidemiological Surveillance, there was a significant increase in the identification of infections. (2.) Relocating to a new building and hiring of a nurse with the exclusive purpose of controlling infection. (3.) Change in antibiotic prophylaxis to cefazolin. In 1997, a surgical-site infection outbreak was detected and controlled.



($P=0.01$; Figure). Those figures remained stable, except that in 1997 there was an outbreak of infection that increased the rate to 3%. That rate remained stable in 1998. With regard to the prevalence of methicillin-resistant *S aureus*, we went from 65.3% at the beginning of the program to 39.3% from 1995 through 1998.

In conclusion, the introduction of the Hospital Infection Control Program was extremely beneficial in our institution, because we started out with a 17% real SSI rate, and it has decreased to 2.5%. According to Haley et al,⁴ the addition of either an effective hospital epidemiologist or a

nurse per 250 beds to perform surveillance and to control infections was estimated to decrease the percentage of infections by 35% in surgical wounds. Greco et al demonstrated that the reduction in surgical-wound infection may reach 50%.⁵ In our study, the decrease reached 80% in these 10 years. A change in the sensitivity profile of the *S aureus* was also reported by Nettleman et al,⁶ who observed that feedback to the healthcare providers has also been shown to reduce rates of methicillin-resistant *S aureus*. The present work reinforces the need for a well-structured infection control program with specialized professionals.

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Effect of Dispensers and Hand Antiseptic on Hand Hygiene

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Muto and colleagues from the University of Virginia Health System recently reported a study designed to improve healthcare workers' compliance with hand hygiene after patient contact by use of an alcohol-based hand antiseptic. Six commercially available alcohol-based hand antiseptics were evaluated. The one most pleasing to the evaluators' hands was selected for the study. Baseline handwashing rates were assessed on two medical wards. Alcohol dispensers were mounted by every door on the two wards. An educational campaign was conducted with four weekly visits to these floors to remind and

reinstruct staff about the use of the alcohol dispensers and to address questions. After 2 months, handwashing rates were reassessed. The study was set in a university hospital.

The baseline handwashing rate was 60% (76/126). Physicians were most compliant (83%), followed by nurses (60%), technologists (56%), and housekeepers (36%). Two months later, overall hand-hygiene rates had decreased to 52% ($P=.26$). Nurses were most compliant (67%), followed by technologists (57%), physicians (29%), and housekeepers (25%). Physician compliance was associated with compliance by attending physicians, whose example was usually followed by all other physicians on rounds.

The authors concluded that a brief educational campaign and installation of dispensers containing a rapidly acting hand-hygiene product near hospital rooms did not affect hand-hygiene compliance. The behavior of attending physicians was predictive of handwashing rates for all others in the attending's retinue. Compliance with hand washing after half of all patient contacts was a result of perfect compliance by some and total noncompliance by others being observed.

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