

INTRODUCTION

Currently, surgical site infections represent on average 15% of all infections acquired during health care, the third most frequent infectious complication in the hospital. Although these data, it is estimated that 40 to 60% of these infections can be prevented. Within this context, one of the key elements so that there is a reduction of infections in clean surgery is the engagement of the multidisciplinary team within the Operating Room, and developing effective actions for continuous improvement process and consequently improving the quality of health care.

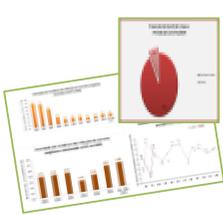
AIM

Promote continuous improvement of safe health care practices, minimizing the risk of surgical site infection, prevention and reducing adverse events that compromise the quality of health care services.

MATERIALS/METHODS

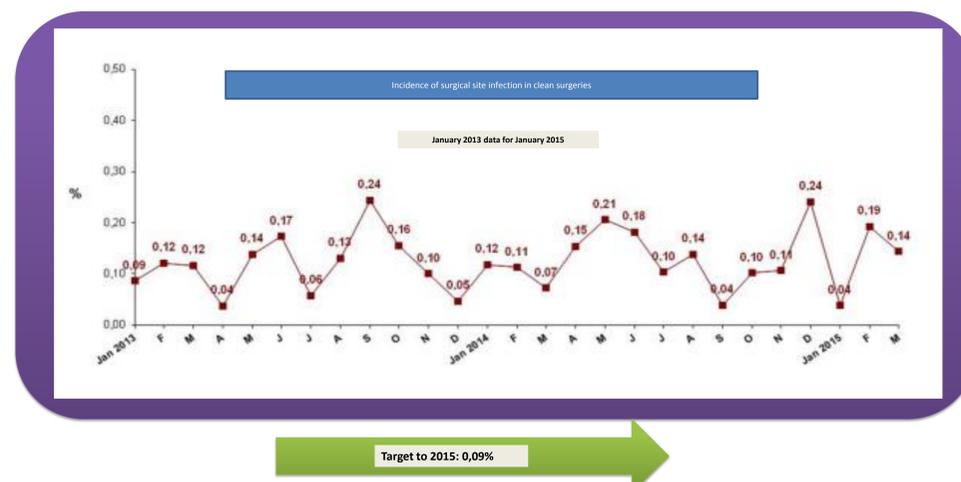
Action plan

1. Monitoring of indicators related to prevention and ISC control for monitoring the quality of care and direct actions (SCIH / Nurse and areas reference professionals). (Figure 1)
2. Direct action / training to the medical staff and employees of the multidisciplinary team regarding Best Practices for Surgical Site Infection Prevention. (Figure 2)
3. Hospital Marketing program to improve adherence to Hand Hygiene. (Figure 3)
4. Cleaning Recall (using protein tests); monitoring of quality indicators. (Figure 4)
5. Skin preparation: development strategy for standardization of impregnated towels (Locomotive Program, Surgical Department, Obstetric Department, SCIH):
 - ✓ Availability of material in Pyxis to all inpatient units Preoperative bathing in CMC units and flow outpatients Of scientific material available to all teams.
 - ✓ Training development with technical experts from companies. (Figure 5)
6. home preparation of the skin with bath with CHG in partnership between the Locomotive of the Program Assistance Center, Pharmacy and HomeCare.
- ✓ 7. Providing training e-learning Surgical Site Infection Prevention .(Figure 6)



RESULTS

The infection rate in 2012 decreased from 0.21% to 0.17%, then the program measures were readjusted reducing to 0.12% in 2013, in 2014 the shares were held, where we achieved the result of 0, 13%. Currently we are working with a challenging target of reducing this number to 0.09%.



CONCLUSION

The strategy process improvement and consequent reduction of the infection rate in clean surgeries corroborated with the decrease of errors in the application of these protocols and became noticeable increasing process safety and increased awareness of the professionals involved in the program.

REFERENCES

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