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Promoting and protecting the health of the public and the environment

South Carolina Department of Health and Environmental Control

C. Earl Hunter, Commissioner

February 1, 2010

2009 Hospital Infections Disclosure Act (HIDA)
Annual Report to the General Assembly on Hospital Acquired Infections

2009 HIDA Annual Report to the General Assembly

The 2009 Hospital Infections Disclosure Act (HIDA) Annual Report to the General Assembly is submitted by the SC Department of Health and Environmental Control in Compliance with the S.C. Code Sections 44-7-2410, 44-7-2460 (2007 Cum. Supp.) (2006 S.C. Acts 293) "Hospital Infections Disclosure Act" (HIDA). Additionally, Act 119 of 2005 mandates that agencies provide all reports to the General Assembly in an electronic format.

S.C. Code Section 44-7-2440 of the "Hospital Infections Disclosure Act" (HIDA) defines the requirements for the annual progress report. In June of 2007, HIDA was amended to allow phasing in of healthcare acquired infection reporting requirements.

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February 2010

Hospital Infections Disclosure Act (HIDA)
Annual Report to the General Assembly
2009 Hospital Acquired Infections
(December 1, 2008 – November 30, 2009)

Executive Summary

The February 2010 HIDA report summarizes the hospital acquired infections (HAI) data for the 2009 HIDA reporting period (December 1, 2008 – November 30, 2009). The complete set of Individual Hospital Reports and the HAI Comparison Reports are attached in the **Appendices**. This progress report includes a discussion of findings, conclusions, trends, and policy issues.

In February 2009, DHEC submitted the first HIDA Annual Report with data from hospital acquired infections (HAI) reported for July 2007 through November 2008. An extensive description of HIDA implementation can be found in the DHEC February 23, 2009 report to the legislature on the website: http://www.scstatehouse.gov/reports/reports.html#h.

Reporting requirements: The number of hospitals required to report HAIs increased for this reporting period from sixty-five to seventy-nine hospitals. Most of the new facilities were Long Term Acute Care Hospitals (LTAC) that were required to report central line associated bloodstream infections (CLABSI) infections for the first time in 2009. One new hospital was added during this year. Specific reporting requirements are listed below. HIDA allows for DHEC to phase in new reporting requirements. For the coming year, no new requirements have been announced because state budget cuts have reduced DHEC staff from three FTEs to 2.15 FTEs leaving no time to plan and implement expanded reporting requirements.

HIDA Reports: DHEC continues to require hospitals to use the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) reporting system and assign rights to DHEC to retrieve the data for public reports. In compliance with HIDA, DHEC has released hospital risk adjusted infection rate reports to the public every six months since the first report was published in February 2008. The mid year report is a preliminary six month report and the Annual report has 12 months of data. These can be found on the DHEC website at www.scdhec.gov/hai. See also **Appendix F** for the 2009 Individual Hospital HIDA Reports.

Comparison Reports: For each HIDA Annual Report, DHEC uses standardized infection ratios (SIR) to compare hospitals. This standard data comes from the NHSN reporting system that is used by almost 2,500 hospitals nationwide, including South Carolina. The number of NHSN hospitals has increased from about 400 hospitals in 2006 as a result of mandatory reporting laws now passed in 21 states. The SIR is the best way we have at this time to compare a hospital to others like it nationally. They are not a good way to compare from one year to the next, because the national standard infection rates change each year. Hospitals in South Carolina and all across the country are implementing HAI prevention programs and reducing their infection rates. As the national SIRs improve, the challenge for each hospital will be to continue to improve just to keep

up with the national trend. As mandatory public reporting expands, the CDC and the states are looking for ways to improve the way we use the data.

For this 2009 data report, the majority of South Carolina hospitals were statistically "not different" from the SIR in the standard national population in all categories. For the nine surgical procedures, a total of five SIRs were "lower" (better) than the national standard population, and 253 SIRs were "not different", and fifteen SIRs were "higher". For the eight CLABSI locations, two SIR were lower than the national standard, and 108 SIRs were not different, and six SIRs were higher. See **Appendix E** for the HAI SIR Comparison Summary and the surgical procedure specific reports for each hospital.

Discussion of Issues

Validation: HIDA requires DHEC to ensure the accuracy and completeness of the hospital reports for public reporting. Only 13 hospital validation site visits were conducted last year, in part due to state budget cuts for travel. Other methods of validation were used to fill in the gap, such as reviewing the computer data base for obvious errors. However, there is no substitute for on site hospital visits to ensure that infections were identified and reported and that the numbers of procedures were accurately reported so that infection rates would not be wrong. All of the following problems require site visits to detect and could affect the accuracy of the public report:

- Validate the accuracy of the total numbers of procedures performed
- Search for unreported SSIs or CLABSIs
- Validate the ASA score, surgical wound classification, and surgery duration information entered into the NHSN database for risk adjustment
- Validate the severity and when and how the SSI was found
- Provide on site NHSN internal validation education

HIDA Advisory Committee: (See Appendix C) At this time, there are six vacancies in the 24 member advisory committee. DHEC has begun efforts to recruit new members.

Laws/ Regulations: DHEC has written draft HIDA regulations and has begun the process to submit them according to the legislative requirements..

DHEC's request to amend HIDA to allow staff more time to prepare the Annual reports is desperately needed. The report is complex and time consuming. In addition to creating the reports and sending the Annual Report to the legislature, the public reporting website needs to be updated at the same time. The current time frame is unworkable.

Focus on prevention: In 2009, Congress passed a law that included a requirement for states receiving Preventive Health Block Grants funds to send a notice of intent to submit a Healthcare Associated Infection (HAI) Prevention Plan to the U.S. Department of Health and Human Services (DHHS) by January 1, 2010. DHEC submitted a state plan **(see Appendix G**). States were also offered the opportunity to request stimulus funds under the Recovery Act (ARRA) to implement a state HAI prevention plan. DHEC received temporary stimulus funding for $201, 800 through the CDC for "Building and Sustaining State Programs to Prevent Healthcare-associated Infections" grant. While HIDA infection rate data will be essential for measuring outcomes of the prevention

efforts, the only funds that directly apply to HIDA are $10,000 in surveillance training funds for hospital and public health staff.
Beginning in October 2009, and extending through 2011, these funds will be used to:

- fund a 0.50 FTE HAI Prevention Planning Coordinator (combined 0.25 FTE from Activity A -Planning and 0.25 FTE from Activity C –developing Prevention Collaboratives)
- support training for public health staff to develop HAI prevention capacity (Surveillance, Collaboratives, Outbreak Investigations, Data – Outcome measures)
- support training for healthcare workers regarding best practices for surveillance and prevention through contracts for Activity B-Surveillance and Activity C-Collaboratives and hospital site visit support for new NHSN users.
- establish "contracted equivalent" support from the SCHA and ORS to support the HAI Planning Coordinator with logistical and operational support for planning and for the central line associated bloodstream infections (**CLABSI**) prevention collaborative.
- expand data for reports and outcome measures to include administrative claims data from the Office of Research and Statistics (**ORS**).

The amount of funding received in the ARRA grant is short term and not sufficient to build and sustain a public health prevention program. Therefore, DHEC also submitted a request to CDC for grant funding to support the HAI prevention efforts. At this time, CDC is not certain if these funds will actually become available.

Partnership Organization and Advisory Committee - South Carolina Alliance for Infection Prevention (SCHAIP): A key component in successful HAI prevention efforts is having effective partnership. During the process of working with the DHEC HIDA Advisory Committee, there were many discussions about the need to prevent infections, not just count them. Out of these discussions, the SC Hospital Association took the lead to form the South Carolina Alliance for Infection Prevention (**SCHAIP**) and, along with DHEC and APIC, brought the state partners together for the purpose of implementing a coordinated, effective approach to infection prevention initiatives in SC. This partnership serves as the multi-disciplinary advisory taskforce required for the HAI Prevention Plan. SCHAIP partners include SCHA, DHEC, APIC, HAI subject area experts, associations representing the continuum of care, state and federal agencies, and consumers. SCHAIP provides the statewide organizational foundation to coordinate, facilitate, and support the implementation of the HAI Prevention Plan in SC (**Appendix G).** Members also include representatives from Health Sciences South Carolina **(HSSC).**

Successes and Challenges: Healthcare acquired infections are considered one of the top ten public health problems. Many healthcare and infection prevention professionals/ organizations consider HAI public reporting (transparency) as an important step toward promoting HAI prevention in healthcare facilities. While all infections are not preventable, many are when the healthcare teams work together to implement prevention guidelines and ensure a culture of safety for their patients. They are encouraged to work toward a target of ZERO infections. As a result of HIDA, South Carolina citizens have access to hospital specific infection rates and public health has the data needed to measure progress toward state and national goals.

The challenges include hospital staffing shortages and high turnover. The NHSN data system is labor intense and requires infection prevent expertise to report HAIs based on specific surveillance case definitions. Some hospitals have to manually enter a lot of the data because they have not yet

automated electronic transfer of medical information into NHSN. Anything that takes the Infection Preventionist away from preventing infections is a problem. However measuring progress and outcomes is also essential to evaluate prevention efforts. DHEC and CDC are searching for ways to streamline and reduce the burden of reporting.

There is a need for an ongoing state infection prevention training program for the multidisciplinary staff in all healthcare facilities, not just hospitals. The public health staff is strained to sustain the progress with shrinking resources. Expanding the public health HAI program to promote prevention is not possible without additional funding. These needs and more are identified in the SC HAI Prevention Plan **(Appendix G).**

Acknowledgements: DHEC acknowledges that the HIDA achievements are made possible by the combined efforts of DHEC staff, the hospitals' infection prevention staff, the active participation of the HIDA Advisory Committee and subcommittees, and the effective partnerships established with the Association of Professionals in Infection Control and Epidemiology (APIC-Palmetto), the SC Hospital Association (SCHA), and the S.C. Office of Research and Statistics (ORS).

Background:

The Centers for Disease Control and Prevention (CDC) has identified HAIs as one of the "Top Ten Public Health Problems" in the US and public reporting of HAIs is an important component of national HAI elimination efforts. Based upon 2002 infection data, CDC estimates that 1.7 million healthcare-associated infections occur in U.S. medical facilities each year; and these infections resulted in as many as 99,000 deaths. Based upon cost estimates, adjusted to the 2007 consumer price index, the direct costs to hospitals for inpatient services for HAIs ranged from $35.7 to $45 billion in additional healthcare costs annually. Many HAIs are preventable, with estimates ranging from 20% to 70% http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf .

Eliminating healthcare-associated infections is a top priority for CDC. Tracking and reporting of healthcare-associated infections is an important step toward healthcare transparency. Infection data can give healthcare facilities, patients and public health agencies the knowledge needed to design and implement prevention strategies that protect patients and save lives.

For the 2009 HIDA reporting period, the following surgical procedures, central line locations, and lab reports of MRSA positive blood cultures were reportable:

1. Surgical Site Infections (SSI) (see Appendix E): Report for the following procedures, in all hospitals where these procedures are performed (except where designated only for hospitals ≤ 200 beds).

- Coronary Artery Bypass Graft (CBGB) (both chest and donor site incisions)
- Coronary Artery Bypass Graft (CBGC) (with chest incision only)
- Hysterectomy (abdominal)
- Hip – replacement
- Knee – replacement
- Colon - (only report from hospitals with 200 beds or less)
- Gallbladder (rotated off the list after June 30, 2009)

- Hysterectomy (vaginal) (rotated off the list after June 30, 2009)
- Spinal fusion (added in January 2009 and rotated off the list after June 2009)

2. Central Line Associated Bloodstream Infections (CLABSI) (see Appendix E)
All locations listed in the following categories are reportable inpatient units.

- Adult Medical and/or Surgical Critical Care Units (all combinations of Medical and Surgical, unless designated as other Specialty Location.)
- Pediatric Medical and/or Surgical Critical Care Units, (all combinations of Medical and Surgical, unless designated as other Specialty Location.)
- All inpatient locations- (in hospitals of **200** beds or less),
- Inpatient Rehabilitation

Specialty Care Areas

- Long Term Acute Care (LTAC)

3. Methicillin resistant Staphylococcus aureus (MRSA) bloodstream infections – Lab Reporting: Laboratories are required to report positive MRSA blood cultures to DHEC. This information is matched to hospital billing data by the Office of Research and Statistics (ORS). (See **Appendix D** for the 2009 Summary.)

Key Abbreviations Found in the HAI Public Report

APIC - Association of Professionals in Infection Control and Epidemiology
CDC - Centers for Disease Control and Prevention
CI – Confidence Intervals
CLABSI - Central Line-Associated Bloodstream Infection
CMS - Centers for Medicare and Medicaid Services
DHHS - Department of Health and Human Services (U.S.)
HAI - Hospital-Acquired Infection
HICPAC - Healthcare Infection Control Practices Advisory Committee
HIDA – Hospital Infections Disclosure Act, South Carolina
ICD-9 - International Classification of Diseases, Ninth Revision
MDRO - Multidrug-Resistant Organism
MRSA - Methicillin-Resistant *Staphylococcus aureus*
NHSN - National Healthcare Safety Network
NQF - National Quality Forum
POA - Present on Admission
QIO - Quality Improvement Organization
SCIP - Surgical Care Improvement Project
SHEA - Society for Healthcare Epidemiologists of America
SIR – Standardized Infection Ratio
SSI - Surgical Site Infection
VAP - Ventilator-Associated Pneumonia

Appendix A

February 2010
Hospital Infections Disclosure Act (HIDA) Annual Report

HAI Definition of Terms

Appendix B

Definition of Terms
for
Hospital-Acquired Infections (HAI) Public Reports
February 2010

The S.C. Hospital Infections Disclosure Act (HIDA) report includes a number of medical and technical words and terms. Unless you work in the healthcare field or understand statistics, you may be unfamiliar with some of them. Below, we've attempted to explain what the words and labels mean. You do not need to learn all the definitions to understand the HAI Reports.

List of Terms:

Central Line
Central Line Associated Bloodstream Infection (CLABSI)
- Central line days
- CLABSI Infection Rate
- Central Line Utilization Ratio

Confidence Intervals (CI) (and Standardized Infection Ration (SIR)
HIDA Reporting Categories
- Central Line Associated Bloodstream Infections
- Surgical Site Infections
- Ventilator Associated Bloodstream Infections
- Other: Methicillin resistant *Staphylococcus aureus* Bloodstream Infections (MRSA BSI)

Hospital Acquired Infection (HAI):
Infection control (also prevention) processes
Infection Preventionists (IP)
Intensive Care Unit (ICU) (also known as Critical Care Units)
National Healthcare Safety Network (NHSN)
Patient Safety Protocols
Standardized Infection Ratio (SIR): (included in Confidence Interval
Surveillance
- Active Surveillance
- Post discharge surveillance

Surgical Site Infection (SSI)
- SSI Infection Rate
- SSI Basic Risk Index
  - ASA Score
  - Wound Class
  - Duration Cut Point

Validation
Ventilator associated pneumonia

See Abbreviations /Acronyms

Appendix B

Definition of Terms - HAI Public Reports

Central line: This is a flexible tube that is inserted near a patient's heart or into one of the large blood vessels. A central line can be used to give fluids, antibiotics, medical treatments such as chemotherapy, and liquid food if a patient is unable to eat or digest food normally. If it is inserted incorrectly or not cared for properly, a central line can cause dangerous bloodstream infections. Central lines are also called central venous lines, central venous catheters and C-lines.

Central Line-Associated Bloodstream Infection (CLABSI):
When a patient gets a bloodstream infection after having a central line put in (or, in the case of a newborn, an umbilical catheter is also a central line)and the bloodstream infection is not related to an infection in another part of the body,it's considered a CLABSI. According to the CDC, an estimated 248,000 CLABSIs occur in U.S. hospitals each year. These bloodstream infections often lead to longer hospital stays, higher costs, and an increased risk of dying. CLABSIs can be prevented through proper insertion and care of the central line. Every time a patient gets an infection that meets the definition of a CLABSI, hospitals must report it to the National Healthcare Safety Network (NHSN).

> **Central line days:** This is the total number of days a central line is in place for patients in surgical, intensive care, and certain other hospital units. The count is performed at the same time each day; each patient with one or more central lines at the time the count is performed is counted as one central line day. Daily totals are added to get monthly totals.
>
> For example: Five patients on the first day of the month had one or more central lines in place. Similarly, five patients on day 2, two patients on day 3, five patients on day 4, three patients on day 5, four patients on day 6,; and four patients on day 7 had central lines in place. Adding the number of patients with central lines on days 1 - 7 we would have 5 + 5 + 2 + 5 + 3 + 4 + 4 = 28 central line days for the first week. The number of central line-days for the month is simply the sum of the daily counts.
>
> **CLABSI Infection Rate**: The total number of central line-associated bloodstream infections is divided by the number of central line days and multiplied by 1,000 to get the CLABSI rate.
>
> **The Central Line Utilization Ratio**: This is calculated by dividing the number of central line-days by the number of patient-days.

Confidence Intervals (CI) and Standardized Infection Ratios (SIR)

Standardized Infection Ratio: The Standardized Infection Ratio (SIR) is a summary measure used to compare the central line associated bloodstream infection (CLABSI) experience among a group of reported locations or the Surgical Site Infection (SSI)

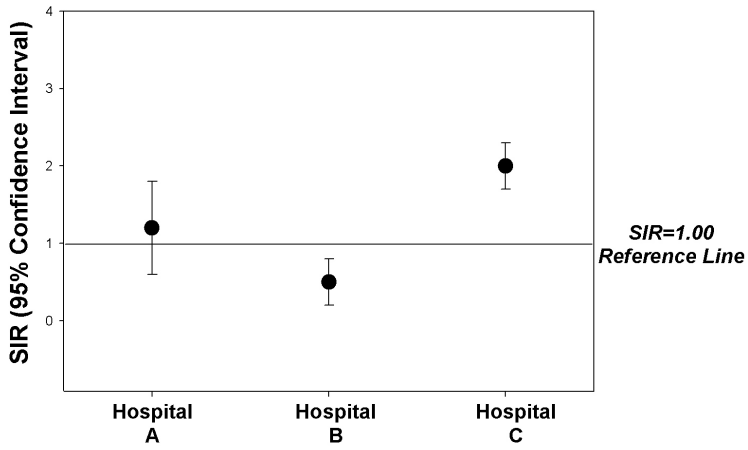
experience among a group of reported procedures to that of a standard population. It is the *observed* number of infections divided by the *expected* number of infections.
For HAI reports, the standard population comes from NHSN data reported from all hospitals using the system in the United States. "Expected" is based on historical data for those procedures at the national level.

Confidence Intervals (CIs)

Because we can never obtain a hospital's true "population" data (e.g. all patients for all time), we use statistical procedures to "estimate" various measurements using "sample" data. Since estimates have "variability" we use 95% confidence limits (or intervals) to describe the variability around the estimate. The confidence interval (CI) gives us the range within which the TRUE value will fall 95% of the time, assuming that the sample data are reflective of the true population.

For HIDA reports, the confidence interval is based on the specific number of infections observed in a hospital during the time period in question and on the number of surgeries or patient-days involving a central line that preceded infections.

If two hospitals have different infection rates, but the confidence intervals for the two rates overlap, then it is reasonably possible that the REAL rates are not different from one another. Below is a graphical example of what CIs would look like if they were in graph form.



Graph Interpretation:

Hospital A: If the 95% confidence interval crosses over the reference line of 1.0, we conclude that the hospital's infection rate is similar (not statistically different) from "expected" (predicted).
Hospital B: If the 95% confidence interval falls completely below the reference line of 1.0, we conclude that the hospital's infection rate is statistically lower than "expected" (predicted).

Hospital C: If the 95% confidence interval falls completely above the reference line of 1.0, we conclude that the hospital's infection rate is statistically higher than "expected" (predicted). All conclusions are based on the assumption that the hospital's patient population is similar to the NHSN pooled patient population.

***Please note that the "expected" number of infections does not mean that you expect to get an infection when you go into the hospital for care**. **The goal is for the hospital is to prevent all HAIs.**

HIDA Reporting Categories:

HIDA lists four reporting categories. Specific medical procedures within each category are being phased in over several years to give hospitals time to put appropriate reporting methods in place.

1. **Surgical Site Infections (SSI)**: These are infections that result from select surgical procedures. All hospitals where these surgeries are performed must report surgical site infections that result. The surgeries required by DHEC are defined by the NHSN and listed on the **HAI Public Report.**

2. **Central Line Associated Bloodstream Infections (CLABSI):** This includes all central line infections that occur in the hospital units specified by DHEC and defined by the NHSN "locations" and listed in the **HAI Report.**

3. **Ventilator associated pneumonia (VAP):** Patients who need mechanical help to breathe have a high risk of developing hospital acquired pneumonia. Reporting for VAP will be phased in when a standardized definition is developed. A standardized definition will make sure that hospitals are reporting the same event and will allow comparison between hospitals.

4. **Methicillin Resistant *Staphylococcus aureus* Bloodstream Infections (MRSA BSI): Clinical laboratories are already required to report MRSA positive blood cultures to DHEC's Bureau of Disease Control "Reportable Conditions" monitoring system.** For more information see the "Other" category in the **HAI Report.**

Hospital Acquired Infection (HAI): The NHSN system has defined a reportable HAI as a localized or systemic condition resulting from adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of hospital admission.

Infection control (or prevention) processes: These are actions taken to prevent infections that can be used in all healthcare settings. They include common infection control practices and principles. The measures can be expanded to meet the needs of

various types of healthcare facilities. A sample of infection control processes that hospitals can require and employees should follow includes:

- Diligent hand hygiene (cleaning)
- Use of personal protective equipment such as gloves, gowns, and /or masks when caring for patients in selected situations to prevent the spread of infections.
- The use of an infection prevention checklist when putting in central lines. Such a list would remind healthcare workers to clean their hands thoroughly, clean the patient's skin before insertion with the appropriate type of soap, wear the recommended sterile gown, gloves and a mask, and place sterile barriers around the insertion site, etc.
- Hospitals should also have procedures to check to make sure that staff is following the prevention procedures.

Infection Preventionists (IP): These health professionals have specialty training in healthcare infection prevention and monitoring.

Intensive Care Unit (ICU) (also known as Critical Care Units): ICU's are hospital units that provide intensive observation and treatment for patients either dealing with, or at risk of developing, life threatening problems. Smaller hospitals typically care for both medical and surgical patients in a combined medical/surgical ICU, while larger hospitals have separate ICUs for medical patients and surgical patients.

National Healthcare Safety Network (NHSN): This is the data reporting system that South Carolina hospitals use to send HAI reports to DHEC. NHSN is a secure, internet-based surveillance (monitoring and reporting) system. It includes, but is not limited to, integrated patient and healthcare personnel safety surveillance systems managed by the CDC's Division of Healthcare Quality Promotion.

Hospitals submit specific infection and procedural information to NHSN. The information is needed to calculate infection rates for each procedure. Hospitals must assign rights to DHEC to collect the data from NHSN so that the information can be reported to the public. DHEC selected this reporting system with the advice of the HIDA Advisory Committee.

Patient Safety Protocols: This is the NHSN manual that contains standardized surveillance definitions and data collection methods that are essential for defining and fairly reporting hospital infection rates. For descriptions of procedures, protocols, and definitions, see the CDC NHSN Manual: Patient Safety Protocols.

Standardized Infection Ratio: (See Confidence Interval for combined description of both definitions.)

SIR Statistical Method: This indirect standardization method accounts for differences in the risk of surgical site infections among a group of procedures. A SIR is the number of observed infections divided by the number of expected infections.

When the SIR is 1.0, the observed number of infections is equal to the number of expected infections. In other words, the SSI experience is the same. When the SIR is above 1.0, the difference above 1.0 is the percentage by which the infection rate is higher than that found in the standard population (which is made up of all hospitals using the NHSN system). When the number is below 1.0, the difference below 1.0 is the percentage by which the infection rate is lower than that experienced by the standard population.

The number of expected infections is calculated by multiplying the number of procedures (at each hospital) by the NHSN Pooled Mean Rate and dividing the product by 100 (to remove the percent). The SIR is then calculated by dividing the sum of the observed number of SSI by the sum of the expected number of SSIs across the different procedures.

***Please note that the "expected" number of infections does not mean that you expect to get an infection when you go into the hospital for surgery**. **The goal is for the hospital is to prevent all HAIs.**

Surveillance: The process of finding and documenting infections.

- **Active Surveillance:** This includes, but is not limited to, active, patient-based, prospective surveillance by a trained infection control professional (IP). The IP seeks out infections during a patient's stay by screening a variety of data sources such as laboratory, pharmacy, admission/discharge/transfer, radiology/imaging, and pathology databases, and patient charts, including history and physical exams notes, nurses/physician notes, and temperature charts. The complete definition for surveillance, including how to capture denominator data to calculate infection rates, is found in each module of the NHSN Manual: Patient Safety Protocols.

- **Post discharge surveillance:** This is the process IPs use to seek out infections after patients have been discharged from the hospital. It includes screening a variety of data sources including readmissions and emergency department visits.

Surgical Site Infection (SSIs):

SSIs are infections that occur as the result of operations defined in the Patient Safety Protocols. Inpatient/outpatient status, type of incision, type of operating room, and other situations are addressed in the definition. For example, under the "other" category, burn wounds are excluded from the definition of a reportable SSI.

All patients receiving surgical procedures that are included in the definition are counted and monitored for infection.

HIDA also requires hospitals to report "risk adjusted" infection rates. The following are definitions that tell how the rates are calculated and what patient risk information goes into risk adjusting the data.

- **SSI Rate**: Surgical site infection rates per 100 operative procedures are calculated by dividing the number of SSIs by the number of total number of specific operative procedures in the reporting period. The results are then multiplied by 100.
  These calculations are performed separately for each type of surgical procedure. They are listed by risk index (see definition, below). Standardized infection ratios are also calculated using indirect standardization or multivariate models.

- **SSI Basic Risk Index:** This is a score used to predict a surgical patient's risk of acquiring a surgical site infection. The risk index score, ranging from 0 to 3, reveals the number of these risk factors present:
  a. The anesthesiologist has given the patient an American Society of Anesthesiologists' (ASA) physical status classification score of 3, 4, or 5.
  b. The operation is classified as contaminated or dirty/ infected.
  c. The operation lasts longer than the duration cut point hours. The duration cut point depends upon the type of operation being performed.

  ASA Score: This is an **a**ssessment by the anesthesiologist of the patient's physical condition prior to surgery. It uses the American Society of Anesthesiologist' (ASA) Classification of Physical Status and is one of the elements that helps determine a patient's SSI Basic Risk index. The ASA scores are:
  1. Normally healthy patient
  2. Patient with mild systemic disease
  3. Patient with severe systemic disease that is not incapacitating
  4. Patient with an incapacitating systemic disease that is a constant threat to life
  5. Moribund patient who is not expected to survive with or without the operation.

  Wound Class: This is an assessment of the degree of contamination of a surgical wound at the time of the operation. The wound class system used in NHSN is an adaptation of the American College of Surgeons wound classification system. Wounds are divided into four classes:

    - **Clean**: An uninfected operative wound in which no inflammation is encountered and the respiratory, alimentary (digestive), genital, or uninfected urinary tracts are not entered. In addition, clean wounds are primarily closed and, if necessary, drained with closed drainage. Operative incisional wounds that follow blunt trauma should be included in this category if they meet the criteria.

    - **Clean-Contaminated**: Operative wounds in which the respiratory, alimentary, genital, or urinary tracts are entered under controlled conditions and without unusual contamination. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are

included in this category, provided no evidence of infection or major break in technique is encountered.

- **Contaminated**: Open, fresh, accidental wounds. In addition, operations with major breaks in sterile technique (e.g., open cardiac massage) or gross spillage from the gastrointestinal tract, and incisions in which acute, nonpurulent inflammation is encountered are included in this category.

- **Dirty or Infected**: Includes old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.

Duration Cut Point: Different procedures have different duration cut points. When a surgery lasts longer than the duration cut point time assigned to that type of operation, infection risks may increase. Cut points are assigned based upon the time that the majority (75%) of those procedures take to perform.
The duration cut point is measured in minutes and is the time between the skin incision and skin closure.

For example: The duration cut point for a coronary bypass graft (chest and donor incision) is five hours and one minute(301 minutes). For an abdominal hysterectomy, the duration cut point is two hours and twenty three minutes(143 minutes).

Validation:

For HIDA, validation is the process of making sure the HAI data reported into NHSN are complete and accurate. That includes SSIs, the total numbers of surgical procedures performed, central line days, and patient information to assign risk scores.
The purpose of the validation visits are to:

- Assess the accuracy and quality of the data submitted to the NHSN
- Provide hospitals with information to help them use the data system.
- Provide education to the IPs and other hospital staff (OR, Anesthesia, IT), if necessary, to improve data accuracy and quality
- Teach the IPs how to validate the data they receive from other departments (e.g. OR.) manually or by computer.
- Look for unreported HAIs
- Assess selected infection control processes
- If data accuracy and/or quality issues are discovered, make recommendations for improvement.

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HIDA Advisory Committee Members

Appendix C

Hospital Infections Disclosure ACT (HIDA)

Advisory Committee - Members

HIDA requires equal membership in the following categories:

Groups	Members
Hospitals	Deb Brumbaugh – Williamsburg Regional Hospital Dr. Rick Foster – SCHA Columbia Dr. John Sanders – Greenville Hosp. Systems Vacant
Consumers	Teresa Arnold – AARP of S.C. Helen Haskell - Mothers Against Med. Error Dianne Parker – Aiken John Ruoff – South Carolina Fair Share
Businesses	Vacant Bruce Barragan – GMK Associates Vacant Vacant
Purchasers of Health Care Services	Julie Royer – ORS Dr. J.B. Sobel - BC/BS Columbia Vacant – DHHS Lynn Martinez Page - Carolina Center for Medical Excellence
Physicians	Dr. Helmut Albrecht – USC School of Medicine Dr. Joe John – VA Med - Charleston Dr. Cassandra Salgado – MUSC Dr. Kevin Shea – Carolinas Hospital System and Pres of SC Infectious Disease Society
Infection Control	Paula Guild – Kershaw Med Ctr Beth Rhoton – MUSC Connie Steed – Greenville HS Vacant

Past Members

Valerie Aiken – Purchasers of Health Care Services
Pete Bailey – Purchasers
Dr. Mary Jo Cagle – Hospitals
Dr. Lydia Chang – Physicians
Sonya Ehrhardt – Infection Control
Leigh Faircloth – Businesses
Dr. Nelson Gunter - Purchasers
Bobby Horton - Businesses
Delores Logan – Purchasers
Cindy Moon – Infection Control
Phil Morris - Consumers
Phyllis Perkins - Businesses
Karl Pfaehler - Hospitals
Zenovia Vaughn – Purchasers of Health Care Services
Dr. Weems – Physicians
Angela Williford – Hospitals
Regina Young - Purchasers

February 2010

Appendix C

February 2010
Hospital Infections Disclosure Act (HIDA) Annual Report

Methicillin resistant *Staphylococcus aureus* (MRSA) State Summary Report

January 1, 2008 – December 31, 2008
January 1, 2009 - June 30, 2009

Appendix D

Methicillin Resistant *Staphylococcus aureus* (MRSA) Bloodstream Infections (BSI)

For this report, MRSA BSIs are based upon positive MRSA lab reports from blood cultures and date of specimen collection and matched to hospital administrative claims data for date of admission.

- Community onset = specimen collected within 72 hours (3 days) of admission and likely to have been present on admission.
- Hospital onset = specimen collected greater than 72 hours (3 days) from admission and potentially a hospital acquired infection (HAIs).

- **2008 Annual MRSA BSI Summary Report : January - December**

    - Bloodstream infections = **1,036 total** MRSA infections reported on 977 individuals
    - *Inpatient admissions or emergency department visits: **845** specimens collected
        - **220** of 845 **collected (26.0%) hospital onset that are potential HAIs**
        - 625 of 845 collected (74.0%) community onset likely to have been present on admission

    * At this time, DHEC is implementing a validation process with record reviews. This process will determine if the community onset and hospital onset categories assigned to each infection by linking the two types of data accurately defines the infection category based upon the clinical record.

- ****2009 Six Month MRSA Summary Report: January –June.**

    - Bloodstream infections = 436 total infections reported on 423 individuals
    - **Inpatient admissions or emergency department visits: **349** specimens collected
        - **77** of 349 **(22.1%) hospital onset that are potential HAIs**
        - 272 of 349 (77.9%) community onset and likely present on admission

    ** The routine process for hospitals to submit complete administrative claims data to ORS may take several months. Therefore, the matched data for the last six months of 2009 is not available.

Reporting Requirements and Data Methodology

In 2008, the South Carolina Department of Health and Environmental Control (DHEC) made Methicillin Resistant *Staphylococcus Aureus* Bloodstream Infections *(*MRSA BSI*)* a laboratory reportable condition. For the Hospital Infections Disclosure Act, a MRSA BSI is defined as a hospital acquired infection when a blood culture collected more than 72 hours after admission becomes positive for MRSA.

DHEC collects MRSA BSI data in three ways: (i) Electronic Laboratory Reporting (ELRs), (ii) disease report cards mailed to DHEC, or (iii) reports entered directly through Carolinas Health Electronic Surveillance System (CHESS). ELRs import directly into CHESS, and results submitted by disease report cards are manually entered into CHESS.

Once the data are in CHESS, a query is run that looks for all MRSAs that have blood listed as the specimen source. Blood specimen source options for MRSA are whole blood, arterial or venous, and very rarely cord blood. Many times, there will be several labs for one person, but that does not translate into a person having multiple infections. If there are fourteen (14) or more days between the first blood draw and the subsequent blood draw, then the latest blood draws are counted as a new infection (event). For example, if a person has their first lab drawn on January 1st and another January 6th and a third one on January 9th, those are all considered the same event and not counted as multiple events. However if a person has their first lab on January 1st and another January 6th and a third on January 27th, the person would be listed as having two events.

After all of the MRSA BSIs have been pulled from CHESS, DHEC gives the file to the Office of Research and Statistics (ORS), where data from DHEC is run through the ORS unique identification system to obtain a unique identifier for linkage to health databases. Unique numbers replace personal identifiers and enables staff to "link across" multiple providers and settings while protecting confidentiality. The data linkage project was approved by the South Carolina Data Oversight Council. The ORS health databases include hospital uniform billing data for inpatient admissions, emergency department visits and outpatient surgeries. The ORS searches health data for encounters one year before and after the event date.

Once the data has been matched, ORS determines whether or not the MRSA BSI is a possible hospital onset or a community onset infection based upon the category definitions described above.

February 2010
Hospital Infections Disclosure Act (HIDA) Annual Report

DHEC Hospital Comparison Reports
2009 Reporting Period
(December 2008 – November 2009)

Reports Include

- DHEC State Summary of Comparison Reports
- Surgical Site Infection Reports by Procedure and Hospital
- Central Line Associated Blood Stream Infections by Location and Hospital

Appendix E

2009 HAI Comparison Summary Report
Standardized Infection Ratio (SIR) for all Hospitals Reporting
(December 2008 –November 2009)

(See the discussion at the end of this report.)

SIR Interpretation:

Statistically Lower than the Standard Population
Statistically Not Different from the Standard Population
Statistically Higher than the Standard Population

***Comments: (number of hospitals not included because of small number of procedures or central lines)**

- Small number of surgical procedures of twenty (20) or fewer is not reported to protect confidentiality.
- Small number of Central Lines of fifty (50) or fewer is not reported to protect confidentiality.
  These hospitals are not included in the percentages, but are included in the total number of hospitals performing those procedures. Reports are preliminary until the 30 day follow-up period for case finding or one year if implants were used.

Surgical Site Infections (SSIs) Summary SIR Reports

Procedure	Hospitals Performing Procedures	Number of hospitals not included in SIR columns due to small numbers	Total Infections	Total Procedures	SIR Lower	SIR Not Different	SIR Higher
	#	#	#	#	# of Hospitals (%)	# of Hospitals (%)	# of Hospitals (%)
Coronary Artery Bypass Graft (Chest and Donor Incision)	16	0	80	3814	2 (12.5)	14 (87.5)	0 (0)
Coronary Artery Bypass Graft (Chest Incision only)	13	7	1	321	0 (0)	6 (100)	0 (0)
Hip Prosthesis – Replacement	54	13	104	5971	0 (0)	37 (90)	4 (10)
Knee Prosthesis --Replacement	54	9	75	9009	1 (2.2)	42 (93.3)	2 (4.4)
Hysterectomy (abdominal)	52	13	99	5376	0 (0)	35 (90)	4 (10)
Hysterectomy (vaginal)	48	16	25	2653	0 (0)	31 (97)	1 (3)
Cholecystec-tomy (Gallbladder)	61	9	41	10080	0 (0)	52 (100)	0 (0)
Colon Surgery (only hospitals with ≤ 200 beds)	31	13	48	925	1 (5.6)	14 (77.8)	3 (16.7)
Spinal Fusions	28	4	43	4151	1 (4.2)	22 (91.7)	1(4.2)

Central Line Associated Blood Stream Infections (CLABSI) SIR Summary Report

Central Line Locations	Hospitals Monitoring Location	Hospitals not included in the SIR and Total Infections column due to small numbers	Total Infections	Total Central Line Days	SIR Lower	SIR Not Different	SIR Higher
	#	#	#	#	# of Hospitals (%)	# of Hospitals (%)	# of Hospitals (%)
Medical- Surgical Critical Care Units	41	2	106	52082	1 (3)	36 (92)	2 (5)
Medical Critical Care Unit	11	0	41	18535	0(0)	10 (91)	1 (9)
Surgical Critical Care Unit	3	0	6	3385	0 (0)	3 (100)	0 (0)
Medical Surgical Pediatric Critical Care Unit	4	0	15	3132	0 (0)	4 (100)	0 (0)
Medical Pediatric Critical Care Unit	1	0	2	1250	0 (0)	1 (100)	0 (0)
Inpatient Wards (Hospitals ≤ 200 beds or less)	42	6	32	37297	0 (0)	36 (100)	0 (0)
Rehabilitation Wards	17	4	11	8855	0 (0)	13 (100)	0 (0)
Long Term Acute Care (LTAC)							
Temporary Central Line	6	0	99	39129	1 (17)	2 (33)	3 (50)
Permanent Central Line	3	0	4	1774	0 (0)	3 (100)	0 (0)

Discussion of HAI Comparison Summary Report Report:

This discussion summarizes the findings in the HAI Comparison Summary Report. The SSI and CLABSI Comparison reports, also found in Appendix D and on the HIDA HAI website (www.scdhec.gov/hai), provide the hospital specific data used to create the summary tables. Each hospital's data is compared to the national standard population of hospitals entering HAI data into the National Healthcare Safety Network (NHSN) data base.

The Standardized Infection Ratio (SIR) is a summary measure used to compare the central line associated bloodstream infection (CLABSI) experience among a group of reported locations or the Surgical Site Infection (SSI) experience among a group of reported procedures to that of a standard population. It is the *observed* number of infections divided by the *expected* (predicted) number of infections. For HAI reports, the standard population comes from CDC NHSN data reported from all hospitals using the system in the United States. "Expected"* is based on historical data for those procedures at the national level.

The SIR for the national standard population SIRs were calculated using the CDC NHSN report published in December 2009, which is based upon data entered into NHSN from 2006 through 2008. (1) Each hospital's SIRs are compared with the national standard population. The December 2009 NHSN report included an additional year's worth of data than the previous November 2008 report.

The additional year of data in this year's report has changed the standard population in several ways. Mandatory reporting has dramatically increased the number of participating hospitals from about 400 to over 2,000 and NHSN opened enrollment to include small hospitals increasing the amount of information entered which in turn can increase or decrease rates. There have been many changes in risk categories for many procedures and these have had an impact on the infection rates. DHEC will continue to work with CDC to identify how to interpret these changes and to how to use the changing data base to evaluate trends and measure progress. Hospitals should use the SIR data and their own data reports to guide prevention efforts.

In this **2009 Hospital Comparison Summary** (SC data entered December 2008 – November 2009), the data includes reports from seventy-nine acute care and rehabilitation hospitals. Some of the hospitals had numbers too small to include in the standardized infection ratio (SIR) reports. The majority of South Carolina hospitals with numbers large enough to publish were statistically "not different" from the SIR in the standard national population in all categories. For the nine surgical procedures, a total of five SIRs were "lower" (better) than the national standard population, and 253 SIRs were "not different", and fifteen SIRs were "higher". For the eight CLABSI locations, two SIR were lower than the national standard, and 108 SIRs were not different, and six SIRs were higher.

Surgical Procedures:
For the coronary artery bypass graft (chest and donor incision), two hospitals (12.5%) of the sixteen hospitals performing these procedures had lower (better) SIRs; fourteen hospitals (87.5%) were not different than the standard SIR; and none were higher. For coronary artery bypass graft (chest incision only) all six hospitals performing these procedures were not different than the standard.

For the other procedures:

- Hip replacements, none were lower, 37 SIRS were not different, and 4 were higher.
- Knee replacement, one was lower, 42 were not different, and 2 were higher.
- Hysterectomy (abdominal), none were lower, 35 were not different, and 4 were higher.
- Hysterectomy (vaginal), none were lower, 31 were not different, and one was higher.
- Gallbladder surgery, none were lower, 52 were not different, and none were higher.
- Colon surgery, one was lower, 14 were not different, and 3 were higher.
- Spinal Fusions, one was lower, 22 were not different, and one was higher.

Central Line Associated Bloodstream Infections: For this reporting period, all hospitals with medical and medical/surgical critical care locations must report; and hospitals with 200 beds or less must also report on inpatient locations outside critical care.

- Critical care locations reporting central line infections: one critical care unit reported a lower SIR, 54 were not different, and three were higher than the standard.
- Locations outside critical care: one reported a lower SIR, 51 were not different, and none were higher than the standard
- All SIRs in Rehabilitation hospital were not different than the standard.
- Long Term Acute Care Hospitals (LTACs)
    - Temporary Central Line: one hospital was lower, two hospitals were not different and three were higher than the standard.
    - Permanent Central Line: All SIRs with a permanent central line in LTACs were not different than the standard.

References:

1. Edwards, Jonathan, et. al., "National Healthcare Safety Network (NHSN) report: Data summary for 2006 through 2008, issued December 2009", Am J Infect Control 2009;37:783-805. http://www.cdc.gov/nhsn/PDFs/dataStat/2009NHSNReport.PDF

2. DHEC HIDA Reports: www.scdhec.gov/hai

Table 1: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Procedure: Coronary Artery Bypass Graft (Chest and Donor Incision) STATEWIDE							
Hospital	**Observed (O) No. of SSI**	**No. of Procedures**	**Statistically 'Expected' (E) No. of SSI[a]**	**Hospital SIR = O ÷ E**	**95% Lower CI**	**95% Upper CI**	**Statistical Interpretation[a]**
Aiken Regional Medical Center	4	47	1.61	2.49	0.68	6.37	Not Different
AnMed Health Medical Center	1	154	4.29	0.23	0.01	1.30	Not Different
Carolinas Hospital System	3	155	4.19	0.72	0.15	2.09	Not Different
Grand Strand Regional Medical Center	4	328	9.45	0.42	0.12	1.08	Not Different
Greenville Memorial Hospital	19	466	14.88	1.28	0.77	1.99	Not Different
Hilton Head Regional Medical Center	4	54	1.86	2.16	0.59	5.52	Not Different
MUSC Medical Center	2	206	6.22	0.32	0.04	1.16	Not Different
McLeod Medical Center - Florence	6	262	7.41	0.81	0.30	1.76	Not Different
Palmetto Health Richland	2	277	7.99	0.25	0.03	0.90	Lower
Piedmont Medical Center	1	88	2.60	0.38	0.01	2.14	Not Different
Providence Hospital	3	609	16.03	0.19	0.04	0.55	Lower
Roper Hospital Inc.	13	325	10.30	1.26	0.67	2.16	Not Different
Self Regional Healthcare	1	77	2.10	0.48	0.01	2.65	Not Different
Spartanburg Regional Medical Center	8	235	7.36	1.09	0.47	2.14	Not Different
St. Francis - Downtown	7	326	12.10	0.58	0.23	1.19	Not Different
Trident Medical Center	2	205	6.48	0.31	0.04	1.12	Not Different

a: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

Click here to return to the report choices and more in-depth information about HAI reporting.

Table 2: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Procedure: Coronary Artery Bypass Graft (Chest Incision Only) STATEWIDE							
Hospital	**Observed (O) No. of SSI**	**No. of Procedures[a]**	**Statistically 'Expected' (E) No. of SSI[b]**	**Hospital SIR = O ÷ E**	**95% Lower CI**	**95% Upper CI**	**Statistical Interpretation[b]**
Carolinas Hospital System	*	8	*	*	*	*	*
Greenville Memorial Hospital	*	6	*	*	*	*	*
Hilton Head Regional Medical Center	*	8	*	*	*	*	*
MUSC Medical Center	1	26	0.42	2.38	0.06	13.25	Not Different
McLeod Medical Center - Florence	0	32	0.45	0.00	0.00	8.24	Not Different
Palmetto Health Richland	0	74	1.24	0.00	0.00	2.97	Not Different
Piedmont Medical Center	0	49	0.84	0.00	0.00	4.41	Not Different
Providence Hospital	0	31	0.46	0.00	0.00	7.99	Not Different
Roper Hospital Inc.	*	16	*	*	*	*	*
Self Regional Healthcare	*	7	*	*	*	*	*
Spartanburg Regional Medical Center	0	52	0.90	0.00	0.00	4.12	Not Different
St. Francis - Downtown	*	11	*	*	*	*	*
Trident Medical Center	*	1	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 3: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Procedure: Hip Prosthesis (Replacement) UPSTATE Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union							
Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	15	*	*	*	*	*
AnMed Health Medical Center	2	52	0.72	2.79	0.34	10.07	Not Different
Baptist Easley Hospital	2	49	0.76	2.62	0.32	9.47	Not Different
Cannon Memorial Hospital	*	11	*	*	*	*	*
Greenville Memorial Hospital	2	106	1.63	1.22	0.15	4.42	Not Different
Greer Memorial Hospital	10	188	2.83	3.53	1.70	6.50	Higher
Hillcrest Memorial Hospital	0	77	0.92	0.00	0.00	4.03	Not Different
Laurens County Healthcare System	6	86	1.24	4.82	1.77	10.50	Higher
Mary Black Healthcare	0	92	1.08	0.00	0.00	3.43	Not Different
Oconee Memorial Hospital	2	121	1.51	1.32	0.16	4.78	Not Different
Patewood Memorial Hospital	1	191	2.00	0.50	0.01	2.78	Not Different
Self Regional Healthcare	2	154	1.89	1.06	0.13	3.82	Not Different
Spartanburg Regional Medical Center	4	310	4.23	0.94	0.26	2.42	Not Different
St. Francis - Downtown	2	133	1.92	1.04	0.13	3.76	Not Different
St. Francis - Eastside	5	362	4.46	1.12	0.36	2.62	Not Different
Upstate Carolina Medical Center	*	13	*	*	*	*	*
Village Hospital	*	10	*	*	*	*	*
Wallace Thomson Hospital	*	6	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

Click here to return to the report choices and more in-depth information about HAI reporting.

Table 3: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hip Prosthesis (Replacement)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	ssicount	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	5	105	1.32	3.79	1.23	8.84	Higher
Carolinas Hospital System	3	130	1.64	1.83	0.38	5.34	Not Different
Chester Regional Medical Center	*	7	*	*	*	*	*
Chesterfield General Hospital	*	9	*	*	*	*	*
Clarendon Memorial Hospital	*	12	*	*	*	*	*
KershawHealth	2	56	0.80	2.49	0.30	8.98	Not Different
Lake City Community Hospital	*	2	*	*	*	*	*
Lexington Medical Center	4	149	2.64	1.51	0.41	3.88	Not Different
Marion County Medical Center	*	10	*	*	*	*	*
Marlboro Park Hospital	*	2	*	*	*	*	*
McLeod Medical Center - Dillon	*	12	*	*	*	*	*
McLeod Medical Center - Florence	5	226	3.46	1.44	0.47	3.37	Not Different
Newberry County Memorial Hospital	0	42	0.31	0.00	0.00	11.82	Not Different
Palmetto Health Baptist	8	190	2.44	3.28	1.42	6.46	Higher
Palmetto Health Richland	7	445	6.05	1.16	0.47	2.39	Not Different
Piedmont Medical Center	0	184	2.25	0.00	0.00	1.64	Not Different
Providence Hospital	1	55	0.62	1.60	0.04	8.92	Not Different
Providence Hospital Northeast	5	451	3.98	1.26	0.41	2.93	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	0	65	0.76	0.00	0.00	4.83	Not Different
Springs Memorial Hospital	0	24	0.34	0.00	0.00	10.86	Not Different
Tuomey	0	50	0.71	0.00	0.00	5.20	Not Different

See the Upstate chart for footnote explanations.

Table 3: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hip Prosthesis (Replacement)
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	ssicount	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Beaufort Memorial Hospital	4	158	1.85	2.16	0.59	5.54	Not Different
Bon Secours - St. Francis Xavier Hospital	2	27	0.38	5.22	0.63	18.86	Not Different
Colleton Medical Center	0	30	0.41	0.00	0.00	8.98	Not Different
Conway Medical Center	1	89	1.21	0.82	0.02	4.59	Not Different
East Cooper Regional Medical Center	1	24	0.32	3.16	0.08	17.59	Not Different
Georgetown Memorial Hospital	0	62	0.80	0.00	0.00	4.61	Not Different
Grand Strand Regional Medical Center	0	200	2.65	0.00	0.00	1.39	Not Different
Hampton Regional Medical Center	*	5	*	*	*	*	*
Hilton Head Regional Medical Center	3	68	0.82	3.67	0.76	10.73	Not Different
Loris Healthcare System	0	29	0.45	0.00	0.00	8.13	Not Different
MUSC Medical Center	4	252	3.03	1.32	0.36	3.38	Not Different
Roper Hospital Inc.	9	460	5.35	1.68	0.77	3.20	Not Different
Summerville Medical Center	0	79	1.11	0.00	0.00	3.32	Not Different
Trident Medical Center	2	153	2.07	0.96	0.12	3.48	Not Different
Waccamaw Community Hospital	0	133	1.94	0.00	0.00	1.90	Not Different

See Upstate chart for footnote explanations

Table 4: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Knee Prosthesis (Replacement)
UPSTATE
Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	19	*	*	*	*	*
AnMed Health Medical Center	1	170	1.62	0.62	0.02	3.44	Not Different
Baptist Easley Hospital	0	80	0.92	0.00	0.00	3.99	Not Different
Cannon Memorial Hospital	0	29	0.36	0.00	0.00	10.19	Not Different
Edgefield County Hospital	*	2	*	*	*	*	*
Greenville Memorial Hospital	2	31	0.39	5.10	0.62	18.42	Not Different
Greer Memorial Hospital	1	220	2.19	0.46	0.01	2.55	Not Different
Hillcrest Memorial Hospital	1	82	0.73	1.37	0.03	7.64	Not Different
Laurens County Healthcare System	1	102	1.00	1.00	0.03	5.59	Not Different
Mary Black Healthcare	2	268	2.22	0.90	0.11	3.26	Not Different
Oconee Memorial Hospital	2	229	1.88	1.06	0.13	3.84	Not Different
Patewood Memorial Hospital	5	374	2.95	1.69	0.55	3.95	Not Different
Self Regional Healthcare	1	312	2.69	0.37	0.01	2.07	Not Different
Spartanburg Regional Medical Center	2	449	4.38	0.46	0.06	1.65	Not Different
St. Francis - Downtown	0	139	1.34	0.00	0.00	2.76	Not Different
St. Francis - Eastside	2	902	8.64	0.23	0.03	0.84	Lower
Upstate Carolina Medical Center	0	27	0.20	0.00	0.00	18.11	Not Different
Village Hospital	1	44	0.37	2.67	0.07	14.90	Not Different
Wallace Thomson Hospital	*	3	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 4: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Knee Prosthesis (Replacement)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	0	99	0.91	0.00	0.00	4.05	Not Different
Carolina Pines Regional Medical Center	1	36	0.36	2.76	0.07	15.38	Not Different
Carolinas Hospital System	0	187	1.75	0.00	0.00	2.11	Not Different
Chester Regional Medical Center	*	3	*	*	*	*	*
Chesterfield General Hospital	*	15	*	*	*	*	*
Clarendon Memorial Hospital	0	35	0.38	0.00	0.00	9.63	Not Different
KershawHealth	1	49	0.50	2.01	0.05	11.21	Not Different
Lake City Community Hospital	*	2	*	*	*	*	*
Lexington Medical Center	3	242	2.38	1.26	0.26	3.69	Not Different
Marion County Medical Center	*	7	*	*	*	*	*
McLeod Medical Center - Dillon	0	39	0.32	0.00	0.00	11.37	Not Different
McLeod Medical Center - Florence	2	404	4.09	0.49	0.06	1.77	Not Different
Newberry County Memorial Hospital	0	73	0.48	0.00	0.00	7.61	Not Different
Palmetto Health Baptist	5	377	3.17	1.58	0.51	3.69	Not Different
Palmetto Health Richland	8	741	7.02	1.14	0.49	2.25	Not Different
Piedmont Medical Center	1	179	1.57	0.64	0.02	3.55	Not Different
Providence Hospital	0	54	0.45	0.00	0.00	8.26	Not Different
Providence Hospital Northeast	0	111	0.84	0.00	0.00	4.41	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	1	76	0.65	1.54	0.04	8.58	Not Different
Springs Memorial Hospital	0	25	0.26	0.00	0.00	14.00	Not Different
Tuomey	2	163	1.67	1.20	0.15	4.32	Not Different

See the Upstate chart for footnote explanations.

Table 4: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Knee Prosthesis (Replacement)
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Beaufort Memorial Hospital	2	303	2.57	0.78	0.09	2.82	Not Different
Colleton Medical Center	0	36	0.32	0.00	0.00	11.48	Not Different
Conway Medical Center	1	119	1.11	0.90	0.02	5.03	Not Different
East Cooper Regional Medical Center	*	14	*	*	*	*	*
Georgetown Memorial Hospital	2	143	1.32	1.51	0.18	5.45	Not Different
Grand Strand Regional Medical Center	2	274	2.53	0.79	0.10	2.86	Not Different
Hampton Regional Medical Center	*	6	*	*	*	*	*
Hilton Head Regional Medical Center	3	35	0.28	10.68	2.20	31.22	Higher
Loris Healthcare System	0	74	0.87	0.00	0.00	4.26	Not Different
MUSC Medical Center	3	288	2.62	1.15	0.24	3.35	Not Different
Roper Hospital Inc.	14	852	6.76	2.07	1.13	3.47	Higher
Summerville Medical Center	0	129	1.24	0.00	0.00	2.98	Not Different
Trident Medical Center	1	128	1.18	0.85	0.02	4.74	Not Different
Waccamaw Community Hospital	2	209	2.17	0.92	0.11	3.32	Not Different

See Upstate chart for footnote explanations

Table 5: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hysterectomy (Abdominal)
UPSTATE
Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	8	*	*	*	*	*
AnMed Health Medical Center	*	5	*	*	*	*	*
AnMed Health Womens And Children	5	136	1.66	3.01	0.98	7.03	Not Different
Baptist Easley Hospital	4	43	0.63	6.32	1.72	16.18	Higher
Cannon Memorial Hospital	*	1	*	*	*	*	*
Greenville Memorial Hospital	10	535	8.69	1.15	0.55	2.12	Not Different
Greer Memorial Hospital	0	21	0.28	0.00	0.00	13.32	Not Different
Mary Black Healthcare	0	113	1.51	0.00	0.00	2.44	Not Different
Oconee Memorial Hospital	0	40	0.60	0.00	0.00	6.17	Not Different
Patewood Memorial Hospital	*	14	*	*	*	*	*
Self Regional Healthcare	2	218	2.63	0.76	0.09	2.75	Not Different
Spartanburg Regional Medical Center	3	278	4.54	0.66	0.14	1.93	Not Different
St. Francis - Eastside	4	336	5.82	0.69	0.19	1.76	Not Different
Upstate Carolina Medical Center	*	8	*	*	*	*	*
Village Hospital	*	2	*	*	*	*	*
Wallace Thomson Hospital	*	6	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

Click here to return to the report choices and more in-depth information about HAI reporting.

Table 5: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hysterectomy (Abdominal)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	1	244	3.24	0.31	0.01	1.72	Not Different
Carolina Pines Regional Medical Center	0	74	1.18	0.00	0.00	3.12	Not Different
Carolinas Hospital System	1	59	0.97	1.04	0.03	5.77	Not Different
Chester Regional Medical Center	*	9	*	*	*	*	*
Chesterfield General Hospital	*	3	*	*	*	*	*
Clarendon Memorial Hospital	0	86	1.17	0.00	0.00	3.16	Not Different
KershawHealth	3	90	1.38	2.17	0.45	6.34	Not Different
Lexington Medical Center	9	297	4.88	1.85	0.84	3.50	Not Different
Marion County Medical Center	4	63	1.05	3.80	1.04	9.74	Higher
Marlboro Park Hospital	*	10	*	*	*	*	*
McLeod Medical Center - Dillon	0	23	0.37	0.00	0.00	9.86	Not Different
McLeod Medical Center - Florence	0	167	2.63	0.00	0.00	1.40	Not Different
Newberry County Memorial Hospital	*	10	*	*	*	*	*
Palmetto Health Baptist	6	151	2.28	2.63	0.97	5.73	Not Different
Palmetto Health Richland	10	302	5.14	1.94	0.93	3.58	Not Different
Piedmont Medical Center	0	118	1.76	0.00	0.00	2.10	Not Different
Providence Hospital	*	1	*	*	*	*	*
Providence Hospital Northeast	1	77	0.94	1.07	0.03	5.96	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	2	60	0.79	2.52	0.31	9.10	Not Different
Springs Memorial Hospital	1	82	1.27	0.79	0.02	4.38	Not Different
Tuomey	2	141	1.80	1.11	0.14	4.03	Not Different

See the Upstate chart for footnote explanations.

Table 5: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hysterectomy (Abdominal)
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Beaufort Memorial Hospital	1	62	0.97	1.03	0.03	5.75	Not Different
Bon Secours - St. Francis Xavier Hospital	8	223	3.10	2.58	1.12	5.09	Higher
Colleton Medical Center	0	24	0.35	0.00	0.00	10.69	Not Different
Conway Medical Center	1	142	1.89	0.53	0.01	2.96	Not Different
East Cooper Regional Medical Center	0	109	1.46	0.00	0.00	2.53	Not Different
Georgetown Memorial Hospital	1	23	0.33	2.99	0.08	16.68	Not Different
Grand Strand Regional Medical Center	0	63	0.97	0.00	0.00	3.81	Not Different
Hampton Regional Medical Center	*	3	*	*	*	*	*
Hilton Head Regional Medical Center	1	72	0.96	1.04	0.03	5.82	Not Different
Loris Healthcare System	2	56	1.10	1.82	0.22	6.58	Not Different
MUSC Medical Center	10	187	3.67	2.72	1.31	5.01	Higher
Roper Hospital Inc.	2	128	2.15	0.93	0.11	3.36	Not Different
Summerville Medical Center	3	151	2.21	1.36	0.28	3.96	Not Different
Trident Medical Center	2	272	4.35	0.46	0.06	1.66	Not Different
Waccamaw Community Hospital	0	30	0.54	0.00	0.00	6.82	Not Different

See Upstate chart for footnote explanations

Table 6: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Hysterectomy (Vaginal)
UPSTATE
Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	5	*	*	*	*	*
AnMed Health Medical Center	*	1	*	*	*	*	*
AnMed Health Womens And Children	0	63	0.48	0.00	0.00	7.66	Not Different
Baptist Easley Hospital	1	56	0.53	1.89	0.05	10.53	Not Different
Greenville Memorial Hospital	1	190	1.65	0.61	0.02	3.39	Not Different
Greer Memorial Hospital	*	17	*	*	*	*	*
Laurens County Healthcare System	0	39	0.40	0.00	0.00	9.30	Not Different
Mary Black Healthcare	0	56	0.47	0.00	0.00	7.87	Not Different
Oconee Memorial Hospital	0	45	0.36	0.00	0.00	10.29	Not Different
Patewood Memorial Hospital	*	2	*	*	*	*	*
Self Regional Healthcare	0	46	0.36	0.00	0.00	10.33	Not Different
Spartanburg Regional Medical Center	1	155	1.40	0.71	0.02	3.97	Not Different
St. Francis - Eastside	1	86	0.85	1.18	0.03	6.58	Not Different
Upstate Carolina Medical Center	*	8	*	*	*	*	*
Village Hospital	*	5	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 6: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Hysterectomy (Vaginal)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	0	43	0.35	0.00	0.00	10.59	Not Different
Carolina Pines Regional Medical Center	*	8	*	*	*	*	*
Carolinas Hospital System	0	53	0.48	0.00	0.00	7.73	Not Different
Chester Regional Medical Center	*	17	*	*	*	*	*
Chesterfield General Hospital	*	4	*	*	*	*	*
Clarendon Memorial Hospital	*	18	*	*	*	*	*
KershawHealth	0	30	0.26	0.00	0.00	14.08	Not Different
Lexington Medical Center	2	185	1.64	1.22	0.15	4.41	Not Different
Marion County Medical Center	*	11	*	*	*	*	*
Marlboro Park Hospital	*	3	*	*	*	*	*
McLeod Medical Center - Dillon	*	1	*	*	*	*	*
McLeod Medical Center - Florence	0	135	1.20	0.00	0.00	3.08	Not Different
Newberry County Memorial Hospital	*	1	*	*	*	*	*
Palmetto Health Baptist	5	308	2.60	1.92	0.62	4.49	Not Different
Palmetto Health Richland	3	138	1.32	2.28	0.47	6.66	Not Different
Piedmont Medical Center	0	72	0.62	0.00	0.00	5.99	Not Different
Providence Hospital Northeast	1	37	0.31	3.24	0.08	18.04	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	0	46	0.38	0.00	0.00	9.74	Not Different
Springs Memorial Hospital	*	6	*	*	*	*	*
Tuomey	0	25	0.20	0.00	0.00	18.88	Not Different

See the Upstate chart for footnote explanations.

Table 6: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Hysterectomy (Vaginal)
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Beaufort Memorial Hospital	0	63	0.54	0.00	0.00	6.87	Not Different
Bon Secours - St. Francis Xavier Hospital	1	87	0.76	1.32	0.03	7.38	Not Different
Conway Medical Center	0	41	0.35	0.00	0.00	10.64	Not Different
East Cooper Regional Medical Center	1	41	0.36	2.75	0.07	15.32	Not Different
Georgetown Memorial Hospital	*	17	*	*	*	*	*
Grand Strand Regional Medical Center	1	74	0.66	1.50	0.04	8.38	Not Different
Hilton Head Regional Medical Center	0	24	0.20	0.00	0.00	18.35	Not Different
Loris Healthcare System	0	62	0.62	0.00	0.00	5.91	Not Different
MUSC Medical Center	4	57	0.55	7.34	2.00	18.79	Higher
Roper Hospital Inc.	1	51	0.54	1.85	0.05	10.32	Not Different
Summerville Medical Center	0	109	0.91	0.00	0.00	4.05	Not Different
Trident Medical Center	2	71	0.66	3.01	0.36	10.87	Not Different
Waccamaw Community Hospital	0	41	0.40	0.00	0.00	9.26	Not Different

See Upstate chart for footnote explanations

Table 7: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Cholecystectomy (Gallbladder)
UPSTATE
Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	0	24	0.13	0.00	0.00	28.31	Not Different
AnMed Health Medical Center	0	233	1.15	0.00	0.00	3.21	Not Different
AnMed Health Womens And Children	0	65	0.21	0.00	0.00	17.86	Not Different
Baptist Easley Hospital	1	258	0.95	1.05	0.03	5.87	Not Different
Cannon Memorial Hospital	0	58	0.18	0.00	0.00	20.21	Not Different
Greenville Memorial Hospital	2	625	3.11	0.64	0.08	2.32	Not Different
Greer Memorial Hospital	0	149	0.64	0.00	0.00	5.80	Not Different
Hillcrest Memorial Hospital	0	159	0.72	0.00	0.00	5.10	Not Different
Laurens County Healthcare System	1	111	0.63	1.59	0.04	8.88	Not Different
Mary Black Healthcare	1	200	0.85	1.17	0.03	6.54	Not Different
Oconee Memorial Hospital	0	323	1.31	0.00	0.00	2.81	Not Different
Patewood Memorial Hospital	0	21	0.09	0.00	0.00	41.22	Not Different
Self Regional Healthcare	1	185	0.78	1.28	0.03	7.11	Not Different
Spartanburg Regional Medical Center	4	494	2.97	1.34	0.37	3.44	Not Different
St. Francis - Downtown	2	701	3.85	0.52	0.06	1.88	Not Different
St. Francis - Eastside	0	33	0.19	0.00	0.00	19.58	Not Different
Upstate Carolina Medical Center	0	57	0.25	0.00	0.00	14.67	Not Different
Village Hospital	*	9	*	*	*	*	*
Wallace Thomson Hospital	0	43	0.20	0.00	0.00	18.72	Not Different

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 7: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Cholecystectomy (Gallbladder)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	1	194	0.91	1.10	0.03	6.15	Not Different
Bamberg County Memorial Hospital	*	5	*	*	*	*	*
Barnwell County Hospital	*	13	*	*	*	*	*
Carolina Pines Regional Medical Center	0	146	0.67	0.00	0.00	5.50	Not Different
Carolinas Hospital System	0	253	1.10	0.00	0.00	3.36	Not Different
Chester Regional Medical Center	0	30	0.21	0.00	0.00	17.78	Not Different
Chesterfield General Hospital	0	91	0.28	0.00	0.00	13.28	Not Different
Clarendon Memorial Hospital	0	21	0.14	0.00	0.00	26.02	Not Different
KershawHealth	1	116	0.50	1.99	0.05	11.10	Not Different
Lake City Community Hospital	*	17	*	*	*	*	*
Lexington Medical Center	6	735	3.94	1.52	0.56	3.32	Not Different
Marion County Medical Center	0	86	0.33	0.00	0.00	11.03	Not Different
Marlboro Park Hospital	*	16	*	*	*	*	*
McLeod Medical Center - Darlington	*	2	*	*	*	*	*
McLeod Medical Center - Dillon	0	91	0.41	0.00	0.00	9.11	Not Different
McLeod Medical Center - Florence	0	253	1.31	0.00	0.00	2.82	Not Different
Newberry County Memorial Hospital	0	66	0.17	0.00	0.00	22.09	Not Different
Palmetto Health Baptist	2	375	1.61	1.25	0.15	4.50	Not Different
Palmetto Health Richland	1	212	1.11	0.90	0.02	5.03	Not Different
Piedmont Medical Center	1	361	1.89	0.53	0.01	2.94	Not Different
Providence Hospital	0	138	0.79	0.00	0.00	4.67	Not Different
Providence Hospital Northeast	*	17	*	*	*	*	*

Table 7: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Cholecystectomy (Gallbladder)
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Regional Medical Center Of Orangeburg/Calhoun Counties	2	147	0.52	3.84	0.47	13.89	Not Different
Springs Memorial Hospital	1	124	0.67	1.49	0.04	8.29	Not Different
Tuomey	0	234	0.97	0.00	0.00	3.82	Not Different

See the Upstate chart for footnote explanations.

Table 7: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Cholecystectomy (Gallbladder)
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Beaufort Memorial Hospital	0	121	0.65	0.00	0.00	5.64	Not Different
Bon Secours - St. Francis Xavier Hospital	0	241	1.08	0.00	0.00	3.42	Not Different
Coastal Carolina Medical Center	0	25	0.13	0.00	0.00	28.58	Not Different
Colleton Medical Center	0	93	0.44	0.00	0.00	8.44	Not Different
Conway Medical Center	1	233	0.94	1.07	0.03	5.95	Not Different
East Cooper Regional Medical Center	0	69	0.28	0.00	0.00	13.40	Not Different
Georgetown Memorial Hospital	1	99	0.37	2.69	0.07	15.00	Not Different
Grand Strand Regional Medical Center	3	222	1.71	1.76	0.36	5.14	Not Different
Hampton Regional Medical Center	*	13	*	*	*	*	*
Hilton Head Regional Medical Center	1	69	0.43	2.33	0.06	13.00	Not Different
Loris Healthcare System	0	106	0.72	0.00	0.00	5.10	Not Different
MUSC Medical Center	2	249	1.80	1.11	0.13	4.01	Not Different
Roper Hospital Inc.	2	355	1.77	1.13	0.14	4.07	Not Different
Summerville Medical Center	2	303	1.18	1.69	0.21	6.12	Not Different
Trident Medical Center	1	300	1.26	0.80	0.02	4.44	Not Different
Waccamaw Community Hospital	1	90	0.43	2.34	0.06	13.04	Not Different
Williamsburg Regional Hospital	*	1	*	*	*	*	*

See Upstate chart for footnote explanations

Table 8: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Colon Surgery
UPSTATE
Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
AnMed Health Womens And Children	*	1	*	*	*	*	*
Baptist Easley Hospital	5	28	1.47	3.41	1.11	7.96	Higher
Cannon Memorial Hospital	*	5	*	*	*	*	*
Greer Memorial Hospital	0	42	2.49	0.00	0.00	1.48	Not Different
Hillcrest Memorial Hospital	0	23	1.28	0.00	0.00	2.88	Not Different
Laurens County Healthcare System	1	27	1.56	0.64	0.02	3.57	Not Different
Mary Black Healthcare	0	21	1.01	0.00	0.00	3.65	Not Different
Oconee Memorial Hospital	1	59	3.47	0.29	0.01	1.60	Not Different
Patewood Memorial Hospital	*	7	*	*	*	*	*
St. Francis - Eastside	*	8	*	*	*	*	*
Upstate Carolina Medical Center	4	29	1.87	2.14	0.58	5.48	Not Different
Village Hospital	*	2	*	*	*	*	*

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 8: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Colon Surgery
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Aiken Regional Medical Center	1	120	6.85	0.15	0.00	0.81	Lower
Carolina Pines Regional Medical Center	8	48	2.90	2.76	1.19	5.44	Higher
Chester Regional Medical Center	*	2	*	*	*	*	*
Marion County Medical Center	*	17	*	*	*	*	*
Marlboro Park Hospital	*	6	*	*	*	*	*
McLeod Medical Center - Dillon	*	11	*	*	*	*	*
Newberry County Memorial Hospital	*	12	*	*	*	*	*
Providence Hospital Northeast	*	5	*	*	*	*	*
Springs Memorial Hospital	1	33	2.20	0.46	0.01	2.54	Not Different

See the Upstate chart for footnote explanations.

Table 8: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Procedure: Colon Surgery
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Coastal Carolina Medical Center	*	4	*	*	*	*	*
Colleton Medical Center	3	40	2.29	1.31	0.27	3.83	Not Different
Conway Medical Center	0	63	3.63	0.00	0.00	1.02	Not Different
East Cooper Regional Medical Center	10	84	4.28	2.33	1.12	4.29	Higher
Georgetown Memorial Hospital	*	8	*	*	*	*	*
Hilton Head Regional Medical Center	7	56	3.15	2.22	0.89	4.58	Not Different
Loris Healthcare System	3	35	2.18	1.38	0.28	4.03	Not Different
Summerville Medical Center	1	65	3.23	0.31	0.01	1.73	Not Different
Trident Medical Center	2	23	1.19	1.68	0.20	6.05	Not Different
Waccamaw Community Hospital	1	41	2.47	0.41	0.01	2.26	Not Different

See Upstate chart for footnote explanations

Table 9: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - June 30, 2009 Procedure: Spinal Fusion UPSTATE Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, Oconee, Pickens, Spartanburg and Union							
Hospital	**Observed (O) No. of SSI**	**No. of Procedures[a]**	**Statistically 'Expected' (E) No. of SSI[b]**	**Hospital SIR = O ÷ E**	**95% Lower CI**	**95% Upper CI**	**Statistical Interpretation[b]**
AnMed Health Medical Center	0	92	1.13	0.00	0.00	3.27	Not Different
Greenville Memorial Hospital	2	241	3.84	0.52	0.06	1.88	Not Different
Laurens County Healthcare System	*	18	*	*	*	*	*
Mary Black Healthcare	0	66	0.76	0.00	0.00	4.87	Not Different
Patewood Memorial Hospital	0	71	0.82	0.00	0.00	4.50	Not Different
Self Regional Healthcare	0	193	1.80	0.00	0.00	2.05	Not Different
Shriners Hospitals For Children	0	39	0.77	0.00	0.00	4.79	Not Different
Spartanburg Regional Medical Center	0	192	2.86	0.00	0.00	1.29	Not Different
St. Francis - Downtown	1	225	4.09	0.24	0.01	1.36	Not Different

a: Too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

b: To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

Click here to return to the report choices and more in-depth information about HAI reporting.

Table 9: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Spinal Fusion
MIDLANDS
Aiken, Allendale, Bamberg, Barnwell, Chester, Chesterfield, Clarendon, Darlington, Dillon, Fairfield, Florence, Kershaw, Lancaster, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Sumter and York

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Carolina Pines Regional Medical Center	*	2	*	*	*	*	*
Carolinas Hospital System	1	158	1.99	0.50	0.01	2.80	Not Different
Lexington Medical Center	0	209	2.61	0.00	0.00	1.42	Not Different
McLeod Medical Center - Florence	2	550	9.29	0.22	0.03	0.78	Lower
Palmetto Health Baptist	4	102	1.57	2.55	0.70	6.54	Not Different
Palmetto Health Richland	8	188	3.68	2.18	0.94	4.29	Not Different
Piedmont Medical Center	0	67	0.88	0.00	0.00	4.18	Not Different
Providence Hospital Northeast	1	50	0.65	1.54	0.04	8.58	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	*	15	*	*	*	*	*
Springs Memorial Hospital	*	1	*	*	*	*	*
Tuomey	0	44	0.67	0.00	0.00	5.52	Not Different

See the Upstate chart for footnote explanations.

Table 9: Surgical Site Infection (SSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - June 30, 2009
Procedure: Spinal Fusion
COASTAL
Beaufort, Beaufort, Charleston, Colleton, Dorchester, Georgetown, Hampton, Horry, Jasper and Williamsburg

Hospital	Observed (O) No. of SSI	No. of Procedures[a]	Statistically 'Expected' (E) No. of SSI[b]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[c]
Bon Secours - St. Francis Xavier Hospital	2	402	5.18	0.39	0.05	1.40	Not Different
Conway Medical Center	0	81	1.00	0.00	0.00	3.71	Not Different
East Cooper Regional Medical Center	5	386	4.21	1.19	0.39	2.77	Not Different
Georgetown Memorial Hospital	0	56	1.14	0.00	0.00	3.23	Not Different
Grand Strand Regional Medical Center	2	92	1.24	1.61	0.20	5.81	Not Different
MUSC Medical Center	12	309	5.90	2.03	1.05	3.55	Higher
Roper Hospital Inc.	2	172	2.63	0.76	0.09	2.74	Not Different
Trident Medical Center	1	130	2.29	0.44	0.01	2.43	Not Different

See Upstate chart for footnote explanations

Table 1: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Location: Medical
Surgical Intensive Care Unit
STATEWIDE

Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	43	*	*	*	*	*
Aiken Regional Medical Center	5	2671	4.0	1.3	0.4	2.9	Not Different
AnMed Health Medical Center	4	2401	3.6	1.1	0.3	2.8	Not Different
Baptist Easley Hospital	0	341	0.5	0.0	0.0	7.2	Not Different
Bon Secours - St. Francis Xavier Hospital	5	1805	2.7	1.9	0.6	4.3	Not Different
Cannon Memorial Hospital	0	119	0.2	0.0	0.0	20.7	Not Different
Carolina Pines Regional Medical Center	3	766	1.1	2.6	0.5	7.6	Not Different
Chester Regional Medical Center	0	76	0.1	0.0	0.0	32.4	Not Different
Chesterfield General Hospital	*	9	*	*	*	*	*
Coastal Carolina Medical Center	0	109	0.2	0.0	0.0	22.6	Not Different
Colleton Medical Center	5	841	1.3	4.0	1.3	9.2	Higher
Conway Medical Center	1	988	1.5	0.7	0.0	3.8	Not Different
East Cooper Regional Medical Center	2	511	0.8	2.6	0.3	9.4	Not Different
Greenville Memorial Hospital	14	5005	10.5	1.3	0.7	2.2	Not Different
Greer Memorial Hospital	0	235	0.5	0.0	0.0	7.5	Not Different
Hampton Regional Medical Center	1	136	0.2	4.9	0.1	27.3	Not Different
Hillcrest Memorial Hospital	0	256	0.4	0.0	0.0	9.6	Not Different
Hilton Head Regional Medical Center	4	1103	1.7	2.4	0.7	6.2	Not Different
KershawHealth	0	527	0.8	0.0	0.0	4.7	Not Different
Laurens County Healthcare System	1	372	0.6	1.8	0.0	10.0	Not Different
Lexington Medical Center	10	3244	4.9	2.1	1.0	3.8	Not Different
Loris Healthcare System	0	893	1.3	0.0	0.0	2.8	Not Different

Table 1: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Medical Surgical Intensive Care Unit STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Marion County Medical Center	1	231	0.3	2.9	0.1	16.1	Not Different
Marlboro Park Hospital	1	150	0.2	4.4	0.1	24.8	Not Different
Mary Black Healthcare	2	642	1.0	2.1	0.3	7.5	Not Different
McLeod Medical Center - Dillon	0	62	0.1	0.0	0.0	39.7	Not Different
Oconee Memorial Hospital	0	857	1.3	0.0	0.0	2.9	Not Different
Palmetto Health Baptist	6	2228	3.3	1.8	0.7	3.9	Not Different
Piedmont Medical Center	1	2594	3.9	0.3	0.0	1.4	Not Different
Providence Hospital	2	1881	2.8	0.7	0.1	2.6	Not Different
Providence Hospital Northeast	0	161	0.2	0.0	0.0	15.3	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	4	4238	6.4	0.6	0.2	1.6	Not Different
Roper Hospital Inc.	8	3875	5.8	1.4	0.6	2.7	Not Different
Springs Memorial Hospital	1	1206	1.8	0.6	0.0	3.1	Not Different
St. Francis - Downtown	0	3301	5.0	0.0	0.0	0.7	Lower
Summerville Medical Center	1	923	1.4	0.7	0.0	4.0	Not Different
Trident Medical Center	22	4982	7.5	2.9	1.8	4.5	Higher
Tuomey	2	1754	2.6	0.8	0.1	2.7	Not Different
Upstate Carolina Medical Center	0	349	0.5	0.0	0.0	7.0	Not Different
Village Hospital	0	67	0.1	0.0	0.0	36.7	Not Different
Wallace Thomson Hospital	0	130	0.2	0.0	0.0	18.9	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found

in the Definition of Terms.

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Table 2: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Medical Intensive Care Unit STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Beaufort Memorial Hospital	0	879	1.7	0.0	0.0	2.2	Not Different
Carolinas Hospital System	10	1468	2.8	3.6	1.7	6.6	Higher
Georgetown Memorial Hospital	0	529	1.0	0.0	0.0	3.7	Not Different
Grand Strand Regional Medical Center	1	1194	2.3	0.4	0.0	2.5	Not Different
MUSC Medical Center	4	3899	10.1	0.4	0.1	1.0	Not Different
McLeod Medical Center - Florence	6	3567	6.8	0.9	0.3	1.9	Not Different
Palmetto Health Richland	12	2695	7.0	1.7	0.9	3.0	Not Different
Self Regional Healthcare	1	1828	3.5	0.3	0.0	1.6	Not Different
Spartanburg Hospital for Restorative Care	3	751	1.4	2.1	0.4	6.1	Not Different
Spartanburg Regional Medical Center	2	1079	2.1	1.0	0.1	3.5	Not Different
Waccamaw Community Hospital	2	646	1.2	1.6	0.2	5.9	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 3: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Surgical Intensive Care Unit STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Carolinas Hospital System	5	1309	3.0	1.7	0.5	3.9	Not Different
Grand Strand Regional Medical Center	0	1123	2.6	0.0	0.0	1.4	Not Different
Spartanburg Regional Medical Center	1	953	2.2	0.5	0.0	2.5	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 4: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Pediatric Medical Surgical Intensive Care Unit STATEWIDE							
Hospital	**Observed (O) No. of CLABSI**	**No. of Central Line Days**	**Statistically 'Expected' (E) No. of CLABSI[a]**	**Hospital SIR = O ÷ E**	**95% Lower CI**	**95% Upper CI**	**Statistical Interpretation[b]**
Greenville Memorial Hospital	4	911	2.7	1.5	0.4	3.7	Not Different
MUSC Medical Center	11	1938	5.8	1.9	0.9	3.4	Not Different
McLeod Medical Center - Florence	0	178	0.5	0.0	0.0	6.9	Not Different
Spartanburg Regional Medical Center	0	105	0.3	0.0	0.0	11.7	Not Different

Table 4: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Pediatric Medical Intensive Care Unit STATEWIDE							
Hospital	**Observed (O) No. of CLABSI**	**No. of Central Line Days**	**Statistically 'Expected' (E) No. of CLABSI[a]**	**Hospital SIR = O ÷ E**	**95% Lower CI**	**95% Upper CI**	**Statistical Interpretation[b]**
Palmetto Health Richland	2	1250	1.6	1.2	0.1	4.4	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 5: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR)
Reportable Period: December 1, 2008 - November 30, 2009
Location: All Inpatient Locations
STATEWIDE

Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Abbeville Area Medical Center	*	34	*	*	*	*	*
Aiken Regional Medical Center	8	3605	6.0	1.3	0.6	2.6	Not Different
Allendale County Hospital	1	341	0.4	2.4	0.1	13.6	Not Different
AnMed Health Womens And Children	*	16	*	*	*	*	*
Bamberg County Memorial Hospital	0	263	0.3	0.0	0.0	11.7	Not Different
Baptist Easley Hospital	1	885	1.1	1.0	0.0	5.3	Not Different
Cannon Memorial Hospital	1	231	0.3	3.6	0.1	20.1	Not Different
Carolina Pines Regional Medical Center	4	1935	3.0	1.3	0.4	3.4	Not Different
Chester Regional Medical Center	0	145	0.2	0.0	0.0	21.2	Not Different
Clarendon Memorial Hospital	0	530	0.6	0.0	0.0	5.8	Not Different
Coastal Carolina Medical Center	2	221	0.3	7.5	0.9	27.2	Not Different
Colleton Medical Center	1	2871	3.9	0.3	0.0	1.4	Not Different
Conway Medical Center	1	2721	3.3	0.3	0.0	1.7	Not Different
East Cooper Regional Medical Center	1	1664	2.6	0.4	0.0	2.2	Not Different
Edgefield County Hospital	0	162	0.2	0.0	0.0	19.0	Not Different
Fairfield Memorial Hospital	*	0	*	*	*	*	*
Georgetown Memorial Hospital	1	1204	1.4	0.7	0.0	3.9	Not Different
Greer Memorial Hospital	0	576	0.7	0.0	0.0	5.3	Not Different
Hampton Regional Medical Center	0	247	0.3	0.0	0.0	12.4	Not Different
Hillcrest Memorial Hospital	0	481	0.6	0.0	0.0	6.4	Not Different
Hilton Head Regional Medical Center	2	1720	2.1	1.0	0.1	3.5	Not Different
KershawHealth	3	2674	3.9	0.8	0.2	2.2	Not Different

Table 5: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: All Inpatient Locations STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Lake City Community Hospital	0	53	0.1	0.0	0.0	46.4	Not Different
Laurens County Healthcare System	0	669	1.0	0.0	0.0	3.6	Not Different
Loris Healthcare System	0	1235	1.5	0.0	0.0	2.5	Not Different
Marion County Medical Center	1	661	0.9	1.2	0.0	6.5	Not Different
Marlboro Park Hospital	0	138	0.2	0.0	0.0	22.3	Not Different
Mary Black Healthcare	1	1325	2.3	0.4	0.0	2.4	Not Different
McLeod Medical Center - Darlington	0	329	0.4	0.0	0.0	9.3	Not Different
McLeod Medical Center - Dillon	1	343	0.5	1.9	0.0	10.6	Not Different
Newberry County Memorial Hospital	*	23	*	*	*	*	*
Oconee Memorial Hospital	2	2130	2.8	0.7	0.1	2.6	Not Different
Patewood Memorial Hospital	*	19	*	*	*	*	*
Providence Hospital Northeast	1	603	0.7	1.4	0.0	7.7	Not Different
Springs Memorial Hospital	3	1550	1.8	1.6	0.3	4.8	Not Different
St. Francis - Eastside	0	301	0.5	0.0	0.0	8.2	Not Different
Summerville Medical Center	2	2640	3.2	0.6	0.1	2.3	Not Different
Upstate Carolina Medical Center	0	708	1.2	0.0	0.0	3.0	Not Different
Village Hospital	0	219	0.3	0.0	0.0	14.0	Not Different
Waccamaw Community Hospital	1	1372	1.6	0.6	0.0	3.4	Not Different
Wallace Thomson Hospital	1	453	0.6	1.7	0.0	9.5	Not Different
Williamsburg Regional Hospital	*	0	*	*	*	*	*

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found

in the Definition of Terms.

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Table 6: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Inpatient Rehabilitation Ward STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
AnMed Health Rehabilation Hospital	0	642	0.5	0.0	0.0	7.2	Not Different
Carolinas Hospital System	1	977	0.8	1.3	0.0	7.1	Not Different
Coastal Carolina Medical Center	*	3	*	*	*	*	*
Colleton Medical Center	*	0	*	*	*	*	*
Greenville Memorial Hospital	2	1435	1.1	1.7	0.2	6.3	Not Different
Greenwood Regional Rehabilitation Hospital	*	21	*	*	*	*	*
HealthSouth Rehabilitaion Hospital - Rock Hill	0	392	0.3	0.0	0.0	11.8	Not Different
HealthSouth Rehabilitation Hospital - Charleston	1	628	0.5	2.0	0.1	11.1	Not Different
HealthSouth Rehabilitation Hospital - Columbia	2	973	0.8	2.6	0.3	9.3	Not Different
HealthSouth Rehabilitation Hospital - Florence	4	1717	1.4	2.9	0.8	7.5	Not Different
Laurens County Healthcare System	0	66	0.1	0.0	0.0	69.9	Not Different
Mary Black Healthcare	*	0	*	*	*	*	*
Palmetto Health Baptist	0	98	0.1	0.0	0.0	47.1	Not Different
Regional Medical Center Of Orangeburg/Calhoun Counties	0	234	0.2	0.0	0.0	19.7	Not Different
Roper Hospital Inc.	1	1172	0.9	1.1	0.0	5.9	Not Different
Springs Memorial Hospital	0	280	0.2	0.0	0.0	16.5	Not Different
Waccamaw Community Hospital	0	217	0.2	0.0	0.0	21.3	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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Table 7: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Long Term Acute Care STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Intermedical Hospital of SC	4	6722	11.4	0.4	0.1	0.9	Lower
Kindred Hospital	21	6937	11.8	1.8	1.1	2.7	Higher
North Greenville Long Term Acute Care Hospital	32	7678	13.1	2.5	1.7	3.5	Higher
Regency Hospital of Florence	12	6204	10.5	1.1	0.6	2.0	Not Different
Regency Hospital of Greenville	11	5239	8.9	1.2	0.6	2.2	Not Different
Spartanburg Hospital for Restorative Care	19	6349	10.8	1.8	1.1	2.7	Higher

Table 7: Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR) Reportable Period: December 1, 2008 - November 30, 2009 Location: Long Term Acute Care STATEWIDE							
Hospital	Observed (O) No. of CLABSI	No. of Central Line Days	Statistically 'Expected' (E) No. of CLABSI[a]	Hospital SIR = O ÷ E	95% Lower CI	95% Upper CI	Statistical Interpretation[b]
Kindred Hospital	0	853	1.4	0.0	0.0	2.7	Not Different
Regency Hospital of Florence	1	523	0.8	1.2	0.0	6.7	Not Different
Spartanburg Hospital for Restorative Care	3	398	0.6	4.7	1.0	13.8	Not Different

a. Too few central line days. Reporting on too few central line days is a risk to patient confidentiality and data stability. If there are less than fifty central line days the rate and number of infections will be suppressed until there are more central line days.

b. To learn more about understanding SIRs and their statistical interpretation, please see the Confidence Interval and SIR explanation found in the Definition of Terms.

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February 2010
Hospital Infections Disclosure Act (HIDA) Annual Report

DHEC Individual Hospital HAI Reports
2009 Reporting Period
December 2008 – November 2009

Includes:
Hospital Reports in Alphabetical Order by Licensed Name
for
Surgical Site Infections
Central Line Associated Blood Stream Infections

Appendix F

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Abbeville Area Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	13	*
	1	*	8	*
	2,3	*	3	*
Hip Prosthesis (Replacement)	0	*	6	*
	1	*	8	*
	2,3	*	1	*
Abdominal Hysterectomy	0	*	6	*
	1	*	2	*
Knee Prosthesis (Replacement)	0	*	12	*
	1	*	4	*
	2,3	*	3	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	5	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Abbeville Area Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	*	43	*
All Inpatient Locations	*	34	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

9

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Aiken Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	1	23	4.35
	2	3	24	12.50
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	1	108	0.93
	1	0	74	0.00
	2,3	*	12	*
Colon Surgery	0	0	23	0.00
	1	1	69	1.45
	2	0	24	0.00
	3	*	4	*
Hip Prosthesis (Replacement)	0	1	30	3.33
	1	4	71	5.63
	2,3	*	4	*
Abdominal Hysterectomy	0	0	195	0.00
	1	1	41	2.44
	2,3	*	8	*
Knee Prosthesis (Replacement)	0	0	30	0.00
	1	0	60	0.00
	2,3	*	9	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	35	0.00
	1,2,3	*	8	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors.

For further explanation see Definition of Terms.

b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.

c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.

d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Aiken Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	5	2671	1.9
All Inpatient Locations	9	3844	2.3

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

147

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

40

Total hours per week for infection control activities other than surveillance:

40

Allendale County Hospital

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Procedures that are required to be reported were not performed at this hospital during the time period.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	1	341	2.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

4

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

No

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

15

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

AnMed Health Womens And Children

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	50	0.00
	1	*	15	*
Colon Surgery	0	*	1	*
Abdominal Hysterectomy	0	4	121	3.31
	1	*	15	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	58	0.00
	1,2,3	*	5	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

AnMed Health Womens And Children

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	*	16	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

24

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

12

Total hours per week for infection control activities other than surveillance:

28

AnMed Health Rehabilitation Hospital

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	0	642	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

35

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

AnMed Health Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	1	133	0.75
	2	0	21	0.00
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	124	0.00
	1	0	91	0.00
	2,3	*	18	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	54	0.00
	1	0	36	0.00
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	*	14	*
	1	1	30	3.33
	2,3	*	8	*
Abdominal Hysterectomy	0	*	2	*
	1	*	3	*
Knee Prosthesis (Replacement)	0	0	57	0.00
	1	0	85	0.00
	2,3	1	28	3.57
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.

d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

AnMed Health Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	4	2401	1.7

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

230

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

4

Total hours per week performing surveillance:

65

Total hours per week for infection control activities other than surveillance:

75

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Bamberg County Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	3	*
	1	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Bamberg County Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	263	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

16

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Barnwell County Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	5	*
	1	*	7	*
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Central Line Associated Blood Stream Infection (CLABSI) Rate, Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

10

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

8

Total hours per week for infection control activities other than surveillance:

12

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Beaufort Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	66	0.00
	1	0	40	0.00
	2,3	*	15	*
Hip Prosthesis (Replacement)	0	2	69	2.90
	1	2	78	2.56
	2,3	*	11	*
Abdominal Hysterectomy	0	0	37	0.00
	1	*	19	*
	2,3	*	6	*
Knee Prosthesis (Replacement)	0	2	149	1.34
	1	0	125	0.00
	2,3	0	29	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	45	0.00
	1,2,3	*	18	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Beaufort Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	0	879	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

123

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

40

Total hours per week for infection control activities other than surveillance:

40

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Cannon Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	48	0.00
	1	*	9	*
	2,3	*	1	*
Colon Surgery	0	*	1	*
	1	*	3	*
	3	*	1	*
Hip Prosthesis (Replacement)	0	*	1	*
	1	*	7	*
	2,3	*	3	*
Abdominal Hysterectomy	1	*	1	*
Knee Prosthesis (Replacement)	0	*	4	*
	1	*	10	*
	2,3	*	15	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Cannon Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	119	0.0
All Inpatient Locations	1	231	4.3

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

10

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Carolina Pines Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	84	0.00
	1	0	53	0.00
	2,3	*	9	*
Colon Surgery	0	*	5	*
	1	5	28	17.86
	2	*	12	*
	3	*	3	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*
	1	*	1	*
Abdominal Hysterectomy	0	0	41	0.00
	1	0	30	0.00
	2,3	*	3	*
Knee Prosthesis (Replacement)	0	*	3	*
	1	1	30	3.33
	2,3	*	3	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	5	*
	1,2,3	*	3	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Carolina Pines Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	3	766	3.9
All Inpatient Locations	4	1935	2.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

84

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Carolinas Hospital System - Cedar Tower

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Procedures that are required to be reported were not performed at this hospital during this time period.

Central Line Associated Blood Stream Infection(CLABSI) Rate

Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

35

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

0.25

Total hours per week performing surveillance:

2

Total hours per week for infection control activities other than surveillance:

1.5

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Carolinas Hospital System

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	3	141	2.13
	2	*	14	*
Coronary Bypass Graft (Chest Only Incision)	0,1	*	8	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	152	0.00
	1	0	89	0.00
	2,3	*	12	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	87	0.00
	1	1	68	1.47
	2,3	*	3	*
Hip Prosthesis (Replacement)	0	0	51	0.00
	1	1	62	1.61
	2,3	*	17	*
Abdominal Hysterectomy	0	0	31	0.00
	1	1	24	4.17
	2,3	*	4	*
Knee Prosthesis (Replacement)	0	0	64	0.00
	1	0	97	0.00
	2,3	0	26	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	32	0.00
	1,2,3	0	21	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Carolinas Hospital System

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	10	1468	6.8
Surgical Intensive Care Unit	5	1309	3.8
Inpatient Rehabilitation Ward	1	977	1.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

191

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Chester Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	14	*
	1	*	9	*
	2,3	*	7	*
Colon Surgery	1	*	2	*
Hip Prosthesis (Replacement)	0	*	3	*
	1	*	4	*
Abdominal Hysterectomy	0	*	2	*
	1	*	6	*
	2,3	*	1	*
Knee Prosthesis (Replacement)	1	*	3	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*
	1,2,3	*	16	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Chester Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	76	0.0
All Inpatient Locations	0	145	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

20

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Chesterfield General Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	73	0.00
	1	*	18	*
Hip Prosthesis (Replacement)	0	*	3	*
	1	*	6	*
Abdominal Hysterectomy	0	*	3	*
Knee Prosthesis (Replacement)	0	*	7	*
	1	*	8	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	3	*
	1,2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Chesterfield General Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	*	9	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

31

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Clarendon Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	11	*
	1	*	5	*
	2,3	*	5	*
Hip Prosthesis (Replacement)	1	*	9	*
	2,3	*	3	*
Abdominal Hysterectomy	0	0	66	0.00
	1	0	20	0.00
Knee Prosthesis (Replacement)	0	*	3	*
	1	0	24	0.00
	2,3	*	8	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	17	*
	1,2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Clarendon Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	530	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

38

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

No

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Coastal Carolina Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	12	*
	1	*	11	*
	2,3	*	2	*
Colon Surgery	1	*	3	*
	2	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Coastal Carolina Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	109	0.0
Inpatient Rehabilitation Ward	*	3	*
All Inpatient Locations	2	221	9.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

15

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

24

Total hours per week for infection control activities other than surveillance:

0

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Colleton Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	46	0.00
	1	0	43	0.00
	2,3	*	4	*
Colon Surgery	0	*	3	*
	1	3	30	10.00
	2	*	7	*
Hip Prosthesis (Replacement)	0	*	4	*
	1	0	25	0.00
	2,3	*	1	*
Abdominal Hysterectomy	0	*	17	*
	1	*	5	*
	2,3	*	2	*
Knee Prosthesis (Replacement)	0	*	13	*
	1	0	20	0.00
	2,3	*	3	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Colleton Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	5	841	5.9
Inpatient Rehabilitation Ward	*	0	*
All Inpatient Locations	1	2871	0.3

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

61

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

15

Total hours per week for infection control activities other than surveillance:

25

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Conway Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	154	0.00
	1	1	70	1.43
	2,3	*	9	*
Colon Surgery	0	*	19	*
	1	0	21	0.00
	2	0	20	0.00
	3	*	3	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	48	0.00
	1	0	31	0.00
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	0	25	0.00
	1	1	51	1.96
	2,3	*	13	*
Abdominal Hysterectomy	0	0	113	0.00
	1	1	27	3.70
	2,3	*	2	*
Knee Prosthesis (Replacement)	0	1	38	2.63
	1	0	67	0.00
	2,3	*	14	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	30	0.00
	1,2,3	*	11	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Conway Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	988	1.0
All Inpatient Locations	1	2721	0.4

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

103

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

35

Total hours per week for infection control activities other than surveillance:

5

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

East Cooper Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	50	0.00
	1	*	15	*
	2,3	*	4	*
Colon Surgery	0	3	41	7.32
	1	7	28	25.00
	2	*	14	*
	3	*	1	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	4	263	1.52
	1	1	119	0.84
	2,3	*	4	*
Hip Prosthesis (Replacement)	0	*	5	*
	1	*	18	*
	2,3	*	1	*
Abdominal Hysterectomy	0	0	86	0.00
	1	0	20	0.00
	2,3	*	3	*
Knee Prosthesis (Replacement)	0	*	8	*
	1	*	6	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	26	3.85
	1,2,3	*	15	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors.

For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

East Cooper Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	2	511	3.9
All Inpatient Locations	1	1664	0.6

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

49

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Edgefield County Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Knee Prosthesis (Replacement)	2,3	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Edgefield County Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	162	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

5

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

5

Total hours per week for infection control activities other than surveillance:

5

Fairfield Memorial Hospital

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Procedures that are required to be reported were not performed at this hospital during this time period.

Central Line Associated Blood Stream Infection(CLABSI) Rate

Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

9

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

5

Total hours per week for infection control activities other than surveillance:

5

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Georgetown Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	67	0.00
	1	1	30	3.33
	2,3	*	2	*
Colon Surgery	0	*	1	*
	1	*	7	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	20	0.00
	1	0	23	0.00
	2,3	*	13	*
Hip Prosthesis (Replacement)	0	*	17	*
	1	0	41	0.00
	2,3	*	4	*
Abdominal Hysterectomy	0	*	16	*
	1	*	5	*
	2,3	*	2	*
Knee Prosthesis (Replacement)	0	1	40	2.50
	1	1	91	1.10
	2,3	*	12	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	10	*
	1,2,3	*	7	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.

b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Georgetown Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	0	529	0.0
All Inpatient Locations	1	1204	0.8

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

81

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

35

Total hours per week for infection control activities other than surveillance:

25

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Grand Strand Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	4	267	1.50
	2	0	60	0.00
	3	*	1	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	74	0.00
	1	2	91	2.20
	2,3	1	57	1.75
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	44	0.00
	1	0	46	0.00
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	0	46	0.00
	1	0	141	0.00
	2,3	*	13	*
Abdominal Hysterectomy	0	0	39	0.00
	1	*	18	*
	2,3	*	6	*
Knee Prosthesis (Replacement)	0	0	71	0.00
	1	2	186	1.08
	2,3	*	17	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	45	0.00
	1,2,3	1	29	3.45

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors.

For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Grand Strand Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	1	1194	0.8
Surgical Intensive Care Unit	0	1123	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

160

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

70

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Greenville Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	1	*
	1	10	296	3.38
	2	9	166	5.42
	3	*	3	*
Coronary Bypass Graft (Chest Only Incision)	0,1	*	5	*
	2,3	*	1	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	369	0.00
	1	1	193	0.52
	2,3	1	63	1.59
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	1	105	0.95
	1	1	113	0.88
	2,3	0	23	0.00
Hip Prosthesis (Replacement)	0	*	6	*
	1	2	84	2.38
	2,3	*	16	*
Abdominal Hysterectomy	0	4	284	1.41
	1	6	230	2.61
	2,3	0	21	0.00
Knee Prosthesis (Replacement)	0	*	3	*
	1	*	12	*
	2,3	*	16	*

Greenville Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	130	0.77
	1,2,3	0	60	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Greenville Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	14	5005	2.8
Pediatric Intensive Care Unit	4	911	4.4
Inpatient Rehabilitation Ward	2	1435	1.4

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

567

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

6

Total hours per week performing surveillance:

175

Total hours per week for infection control activities other than surveillance:

65

Greenwood Regional Rehabilitation Hospital

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	*	21	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

37

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

5

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Greer Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	101	0.00
	1	0	38	0.00
	2,3	*	10	*
Colon Surgery	0	*	7	*
	1	0	21	0.00
	2	*	12	*
	3	*	2	*
Hip Prosthesis (Replacement)	0	0	34	0.00
	1	3	114	2.63
	2,3	7	40	17.50
Abdominal Hysterectomy	0	*	17	*
	1	*	3	*
	2,3	*	1	*
Knee Prosthesis (Replacement)	0	1	69	1.45
	1	0	103	0.00
	2,3	0	48	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	14	*
	1,2,3	*	3	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.

d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Greer Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	235	0.0
All Inpatient Locations	0	576	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

30

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Hampton Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	5	*
	1	*	6	*
	2,3	*	2	*
Hip Prosthesis (Replacement)	1	*	4	*
	2,3	*	1	*
Abdominal Hysterectomy	1	*	3	*
Knee Prosthesis (Replacement)	0	*	3	*
	1	*	2	*
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Hampton Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	136	7.4
All Inpatient Locations	0	247	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

8

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

8

Total hours per week for infection control activities other than surveillance:

8

Healthsouth Rehabilitation Hospital - Charleston

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	1	628	1.6

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

37

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthsouth Rehabilitation Hospital - Columbia

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	2	973	2.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

58

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

5

Healthsouth Rehabilitation Hospital - Florence

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	4	1717	2.3

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

48

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthsouth Rehabilitation Hospital - Rock Hill

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Inpatient Rehabilitation Ward	0	392	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

36

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Hillcrest Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	100	0.00
	1	0	47	0.00
	2,3	*	12	*
Colon Surgery	0	*	5	*
	1	*	13	*
	2	*	5	*
Hip Prosthesis (Replacement)	0	0	30	0.00
	1	0	43	0.00
	2,3	*	4	*
Knee Prosthesis (Replacement)	0	0	29	0.00
	1	0	47	0.00
	2,3	*	6	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Hillcrest Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	256	0.0
All Inpatient Locations	0	481	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

22

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Hilton Head Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	3	26	11.54
	2	1	28	3.57
Coronary Bypass Graft (Chest Only Incision)	0,1	*	8	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	33	0.00
	1	0	24	0.00
	2,3	*	12	*
Colon Surgery	0	*	17	*
	1	4	21	19.05
	2	*	17	*
	3	*	1	*
Hip Prosthesis (Replacement)	0	1	26	3.85
	1	2	38	5.26
	2,3	*	4	*
Abdominal Hysterectomy	0	1	57	1.75
	1	*	15	*
Knee Prosthesis (Replacement)	0	*	19	*
	1	*	14	*
	2,3	*	2	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	18	*
	1,2,3	*	6	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Hilton Head Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	4	1103	3.6
All Inpatient Locations	2	1720	1.2

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

51

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Intermedical Center of SC

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Long Term Acute Care - Temporary Central Line	4	6722	0.6

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

23

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

15

Total hours per week for infection control activities other than surveillance:

8

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

KershawHealth

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	60	0.00
	1	1	54	1.85
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	*	4	*
	1	2	49	4.08
	2,3	*	3	*
Abdominal Hysterectomy	0	1	55	1.82
	1	2	31	6.45
	2,3	*	4	*
Knee Prosthesis (Replacement)	0	*	9	*
	1	1	32	3.13
	2,3	*	8	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	20	0.00
	1,2,3	*	10	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

KershawHealth

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	527	0.0
All Inpatient Locations	3	2674	1.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

75

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

10

Kindred Hospital - Charleston

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Long Term Acute Care - Temporary Central Line	21	6937	3.0
Long Term Acute Care - Permanent Central Line	0	853	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

30

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

25

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Lake City Community Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	10	*
	1	*	7	*
Hip Prosthesis (Replacement)	1	*	2	*
Knee Prosthesis (Replacement)	0	*	1	*
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Lake City Community Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	53	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

11

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

8

Total hours per week for infection control activities other than surveillance:

8

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Laurens County Healthcare System

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	54	0.00
	1	1	43	2.33
	2,3	*	14	*
Colon Surgery	0	*	6	*
	1	*	11	*
	2	*	10	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	*	9	*
	1	*	9	*
Hip Prosthesis (Replacement)	0	*	13	*
	1	5	62	8.06
	2,3	*	11	*
Knee Prosthesis (Replacement)	0	0	21	0.00
	1	1	69	1.45
	2,3	*	12	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	13	*
	1,2,3	0	26	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Laurens County Healthcare System

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	372	2.7
Inpatient Rehabilitation Ward	0	66	0.0
All Inpatient Locations	0	669	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

34

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

36

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Lexington Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	5	404	1.24
	1	0	242	0.00
	2,3	1	89	1.12
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	127	0.00
	1	0	74	0.00
	2,3	*	8	*
Hip Prosthesis (Replacement)	0	*	19	*
	1	0	63	0.00
	2,3	2	67	2.99
Abdominal Hysterectomy	0	4	154	2.60
	1	4	125	3.20
	2,3	*	18	*
Knee Prosthesis (Replacement)	0	0	74	0.00
	1	3	121	2.48
	2,3	0	47	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	118	0.85
	1,2,3	1	67	1.49

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Lexington Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	10	3244	3.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

268

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

40

Total hours per week for infection control activities other than surveillance:

40

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Loris Healthcare System

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	47	0.00
	1	0	36	0.00
	2,3	0	23	0.00
Colon Surgery	0	*	6	*
	1	*	14	*
	2	*	11	*
	3	*	4	*
Hip Prosthesis (Replacement)	0	*	4	*
	1	*	18	*
	2,3	*	7	*
Abdominal Hysterectomy	0	*	14	*
	1	0	32	0.00
	2,3	*	10	*
Knee Prosthesis (Replacement)	0	*	6	*
	1	0	42	0.00
	2,3	0	26	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	22	0.00
	1,2,3	0	40	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.

d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Loris Healthcare System

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	893	0.0
All Inpatient Locations	0	1235	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

41

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Marion County Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	50	0.00
	1	0	36	0.00
Colon Surgery	0	*	3	*
	1	*	13	*
	2	*	1	*
Hip Prosthesis (Replacement)	1	*	8	*
	2,3	*	2	*
Abdominal Hysterectomy	0	1	32	3.13
	1	3	22	13.64
	2,3	*	9	*
Knee Prosthesis (Replacement)	1	*	1	*
	2,3	*	6	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	6	*
	1,2,3	*	5	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Marion County Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	231	4.3
All Inpatient Locations	1	661	1.5

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

52

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

30

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Marlboro Park Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	6	*
	1	*	5	*
	2,3	*	5	*
Colon Surgery	1	*	2	*
	2	*	4	*
Hip Prosthesis (Replacement)	1	*	1	*
	2,3	*	1	*
Abdominal Hysterectomy	0	*	5	*
	1	*	5	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*
	1,2,3	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Marlboro Park Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	150	6.7
All Inpatient Locations	0	138	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

15

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Mary Black Healthcare

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	1	129	0.78
	1	0	60	0.00
	2,3	*	11	*
Colon Surgery	0	*	12	*
	1	*	7	*
	2	*	2	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	47	0.00
	1	*	16	*
	2,3	*	3	*
Hip Prosthesis (Replacement)	0	0	41	0.00
	1	0	44	0.00
	2,3	*	7	*
Abdominal Hysterectomy	0	0	89	0.00
	1	0	21	0.00
	2,3	*	3	*
Knee Prosthesis (Replacement)	0	0	138	0.00
	1	1	109	0.92
	2,3	1	21	4.76
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	42	0.00
	1,2,3	*	14	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors.

For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Mary Black Healthcare

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	2	642	3.1
Inpatient Rehabilitation Ward	*	0	*
All Inpatient Locations	1	1325	0.8

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

104

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

McLeod Medical Center - Darlington

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	1	*	1	*
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

McLeod Medical Center - Darlington

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	329	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

37

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

2

Total hours per week for infection control activities other than surveillance:

6

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

McLeod Medical Center - Dillon

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	57	0.00
	1	0	28	0.00
	2,3	*	6	*
Colon Surgery	0	*	5	*
	1	*	3	*
	2	*	2	*
	3	*	1	*
Hip Prosthesis (Replacement)	0	*	4	*
	1	*	8	*
Abdominal Hysterectomy	0	*	12	*
	1	*	11	*
Knee Prosthesis (Replacement)	0	*	15	*
	1	0	24	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

McLeod Medical Center - Dillon

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	62	0.0
All Inpatient Locations	1	343	2.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

31

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

8

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

McLeod Medical Center - Florence

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	4	*
	1	5	210	2.38
	2	1	48	2.08
Coronary Bypass Graft (Chest Only Incision)	0,1	0	31	0.00
	2,3	*	1	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	126	0.00
	1	0	105	0.00
	2,3	0	22	0.00
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	208	0.00
	1	1	283	0.35
	2,3	1	59	1.69
Hip Prosthesis (Replacement)	0	0	35	0.00
	1	2	141	1.42
	2,3	3	50	6.00
Abdominal Hysterectomy	0	0	96	0.00
	1	0	64	0.00
	2,3	*	7	*
Knee Prosthesis (Replacement)	0	0	87	0.00
	1	0	244	0.00
	2,3	2	73	2.74

McLeod Medical Center - Florence

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	86	0.00
	1,2,3	0	49	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

McLeod Medical Center - Florence

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	6	3567	1.7
Pediatric Intensive Care Unit	0	178	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

324

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

3

Total hours per week performing surveillance:

65

Total hours per week for infection control activities other than surveillance:

55

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

MUSC Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	4	*
	1	1	143	0.70
	2	1	58	1.72
	3	*	1	*
Coronary Bypass Graft (Chest Only Incision)	0,1	*	19	*
	2,3	*	7	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	104	0.00
	1	1	84	1.19
	2,3	1	61	1.64
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	100	0.00
	1	5	157	3.18
	2,3	7	52	13.46
Hip Prosthesis (Replacement)	0	3	110	2.73
	1	1	116	0.86
	2,3	0	26	0.00
Abdominal Hysterectomy	0	4	49	8.16
	1	3	89	3.37
	2,3	3	49	6.12
Knee Prosthesis (Replacement)	0	0	119	0.00
	1	2	127	1.57
	2,3	1	42	2.38

MUSC Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	2	27	7.41
	1,2,3	2	30	6.67

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

MUSC Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	4	3899	1.0
Pediatric Intensive Care Unit	11	1938	5.7

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

444

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

6

Total hours per week performing surveillance:

132

Total hours per week for infection control activities other than surveillance:

108

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Newberry County Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	62	0.00
	1	*	4	*
Colon Surgery	0	*	5	*
	1	*	7	*
Hip Prosthesis (Replacement)	0	0	38	0.00
	1	*	4	*
Abdominal Hysterectomy	0	*	9	*
	1	*	1	*
Knee Prosthesis (Replacement)	0	0	58	0.00
	1	*	15	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Newberry County Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	*	23	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

30

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

16

Total hours per week for infection control activities other than surveillance:

8

North Greenville Long Term Acute Care

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Long Term Acute Care - Temporary Central Line	32	7678	4.2

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

Not Available

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

30

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Oconee Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	220	0.00
	1	0	87	0.00
	2,3	*	16	*
Colon Surgery	0	*	11	*
	1	0	29	0.00
	2	*	16	*
	3	*	3	*
Hip Prosthesis (Replacement)	0	1	46	2.17
	1	1	62	1.61
	2,3	*	13	*
Abdominal Hysterectomy	0	0	26	0.00
	1	*	12	*
	2,3	*	2	*
Knee Prosthesis (Replacement)	0	2	121	1.65
	1	0	90	0.00
	2,3	*	18	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	38	0.00
	1,2,3	*	7	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.

d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Oconee Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	857	0.0
All Inpatient Locations	2	2130	0.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

73

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

38

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Palmetto Health Baptist

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	235	0.00
	1	1	121	0.83
	2,3	*	19	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	41	0.00
	1	2	55	3.64
	2,3	*	6	*
Hip Prosthesis (Replacement)	0	3	57	5.26
	1	4	118	3.39
	2,3	*	15	*
Abdominal Hysterectomy	0	3	97	3.09
	1	1	42	2.38
	2,3	*	12	*
Knee Prosthesis (Replacement)	0	1	147	0.68
	1	4	224	1.79
	2,3	*	6	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	3	226	1.33
	1,2,3	2	82	2.44

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Palmetto Health Baptist

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	6	2228	2.7
Inpatient Rehabilitation Ward	0	98	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

254

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

3

Total hours per week performing surveillance:

60

Total hours per week for infection control activities other than surveillance:

60

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Baptist Easley Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	182	0.00
	1	0	70	0.00
	2,3	*	6	*
Colon Surgery	0	*	9	*
	1	*	16	*
	2	*	3	*
Hip Prosthesis (Replacement)	0	*	5	*
	1	1	34	2.94
	2,3	*	10	*
Abdominal Hysterectomy	0	0	29	0.00
	1	*	11	*
	2,3	*	3	*
Knee Prosthesis (Replacement)	0	*	11	*
	1	0	40	0.00
	2,3	0	29	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	28	0.00
	1,2,3	1	28	3.57

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Baptist Easley Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	341	0.0
All Inpatient Locations	1	885	1.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

56

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Palmetto Health Richland

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	2	*
	1	2	218	0.92
	2	0	57	0.00
Coronary Bypass Graft (Chest Only Incision)	0,1	0	49	0.00
	2,3	0	25	0.00
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	110	0.00
	1	0	81	0.00
	2,3	1	21	4.76
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	52	0.00
	1	5	105	4.76
	2,3	3	31	9.68
Hip Prosthesis (Replacement)	0	0	123	0.00
	1	6	261	2.30
	2,3	1	61	1.64
Abdominal Hysterectomy	0	0	142	0.00
	1	6	129	4.65
	2,3	4	31	12.90
Knee Prosthesis (Replacement)	0	1	216	0.46
	1	5	432	1.16
	2,3	2	93	2.15

Palmetto Health Richland

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	66	0.00
	1,2,3	3	72	4.17

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Palmetto Health Richland

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	12	2695	4.5
Pediatric Intensive Care Unit	2	1250	1.6

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

466

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

6

Total hours per week performing surveillance:

172

Total hours per week for infection control activities other than surveillance:

68

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Patewood Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	16	*
	1	*	3	*
	2,3	*	2	*
Colon Surgery	0	*	1	*
	1	*	4	*
	2	*	2	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	45	0.00
	1	0	25	0.00
	2,3	*	1	*
Hip Prosthesis (Replacement)	0	1	106	0.94
	1	0	78	0.00
	2,3	*	7	*
Abdominal Hysterectomy	0	*	7	*
	1	*	7	*
Knee Prosthesis (Replacement)	0	0	199	0.00
	1	5	164	3.05
	2,3	*	11	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*
	1,2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.

b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Patewood Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	*	19	*

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

Not Available

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Piedmont Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	1	67	1.49
	2	0	21	0.00
Coronary Bypass Graft (Chest Only Incision)	0,1	0	31	0.00
	2,3	*	18	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	189	0.00
	1	1	135	0.74
	2,3	0	37	0.00
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	33	0.00
	1	0	33	0.00
	2,3	*	1	*
Hip Prosthesis (Replacement)	0	0	60	0.00
	1	0	118	0.00
	2,3	*	6	*
Abdominal Hysterectomy	0	0	78	0.00
	1	0	29	0.00
	2,3	*	11	*
Knee Prosthesis (Replacement)	0	0	67	0.00
	1	1	100	1.00
	2,3	*	12	*

Piedmont Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	51	0.00
	1,2,3	0	21	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Piedmont Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	2594	0.4

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

176

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

40

Total hours per week for infection control activities other than surveillance:

40

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Providence Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	1	*
	1	3	580	0.52
	2	0	27	0.00
	3	*	1	*
Coronary Bypass Graft (Chest Only Incision)	0,1	0	27	0.00
	2,3	*	4	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	66	0.00
	1	0	54	0.00
	2,3	*	18	*
Hip Prosthesis (Replacement)	0	0	23	0.00
	1	1	31	3.23
	2,3	*	1	*
Abdominal Hysterectomy	2,3	*	1	*
Knee Prosthesis (Replacement)	0	0	23	0.00
	1	0	30	0.00
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Providence Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	2	1881	1.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

152

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

60

Total hours per week for infection control activities other than surveillance:

5

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Providence Hospital Northeast

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	12	*
	1	*	2	*
	2,3	*	3	*
Colon Surgery	1	*	3	*
	2	*	2	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	26	0.00
	1	1	23	4.35
	2,3	*	1	*
Hip Prosthesis (Replacement)	0	4	340	1.18
	1	1	100	1.00
	2,3	*	11	*
Abdominal Hysterectomy	0	1	69	1.45
	1	*	8	*
Knee Prosthesis (Replacement)	0	0	67	0.00
	1	0	42	0.00
	2,3	*	2	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	28	3.57
	1,2,3	*	9	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.

c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Providence Hospital Northeast

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	161	0.0
All Inpatient Locations	1	603	1.7

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

28

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

5

Regency Hospital of SC LLC

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Long Term Acute Care - Temporary Central Line	12	6204	1.9
Long Term Acute Care - Permanent Central Line	1	523	1.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

30

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

8

Regency Hospital of Greenville

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Long Term Acute Care - Temporary Central Line	11	5239	2.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

24

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

15

Total hours per week for infection control activities other than surveillance:

5

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Regional Medical Center of Orangeburg and Calhoun Counties

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	102	0.00
	1	2	44	4.55
	2,3	*	1	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	*	9	*
	1	*	4	*
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	0	26	0.00
	1	0	36	0.00
	2,3	*	3	*
Abdominal Hysterectomy	0	2	48	4.17
	1	*	11	*
	2,3	*	1	*
Knee Prosthesis (Replacement)	0	0	34	0.00
	1	1	36	2.78
	2,3	*	6	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	36	0.00
	1,2,3	*	10	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Regional Medical Center of Orangeburg and Calhoun Counties

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	4	4238	0.9
Inpatient Rehabilitation Ward	0	234	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

171

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

50

Total hours per week for infection control activities other than surveillance:

60

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Roper Hospital Inc.

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	1	*
	1	5	205	2.44
	2	8	119	6.72
Coronary Bypass Graft (Chest Only Incision)	0,1	*	11	*
	2,3	*	5	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	208	0.00
	1	1	111	0.90
	2,3	1	36	2.78
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	90	0.00
	1	2	63	3.17
	2,3	*	19	*
Hip Prosthesis (Replacement)	0	2	202	0.99
	1	6	229	2.62
	2,3	1	29	3.45
Abdominal Hysterectomy	0	1	64	1.56
	1	1	45	2.22
	2,3	*	19	*
Knee Prosthesis (Replacement)	0	3	458	0.66
	1	9	360	2.50
	2,3	2	34	5.88

Roper Hospital Inc.

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	12	*
	1,2,3	1	39	2.56

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Roper Hospital Inc.

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	8	3875	2.1
Inpatient Rehabilitation Ward	1	1172	0.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

260

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

60

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Self Regional Healthcare

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	1	69	1.45
	2	*	8	*
Coronary Bypass Graft (Chest Only Incision)	0,1	*	7	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	120	0.00
	1	1	55	1.82
	2,3	*	10	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	154	0.00
	1	0	39	0.00
Hip Prosthesis (Replacement)	0	0	61	0.00
	1	2	78	2.56
	2,3	*	15	*
Abdominal Hysterectomy	0	2	197	1.02
	1	0	21	0.00
Knee Prosthesis (Replacement)	0	0	153	0.00
	1	1	122	0.82
	2,3	0	37	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	41	0.00
	1,2,3	*	5	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.

b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Self Regional Healthcare

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	1	1828	0.5

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

158

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

50

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Shriners Hospitals For Children

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	1	0	37	0.00
	2,3	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Shriners Hospitals For Children

Central Line Associated Blood Stream Infection (CLABSI) Rate, Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

Not Available

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

7

Total hours per week for infection control activities other than surveillance:

13

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Spartanburg Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	6	155	3.87
	2	2	80	2.50
Coronary Bypass Graft (Chest Only Incision)	0,1	0	32	0.00
	2,3	0	20	0.00
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	241	0.00
	1	1	174	0.57
	2,3	3	79	3.80
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	77	0.00
	1	0	107	0.00
	2,3	*	8	*
Hip Prosthesis (Replacement)	0	1	81	1.23
	1	2	188	1.06
	2,3	1	41	2.44
Abdominal Hysterectomy	0	1	150	0.67
	1	2	92	2.17
	2,3	0	36	0.00
Knee Prosthesis (Replacement)	0	0	100	0.00
	1	0	293	0.00
	2,3	2	56	3.57

Spartanburg Regional Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	92	0.00
	1,2,3	1	63	1.59

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Spartanburg Regional Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	2	1079	1.9
Pediatric Intensive Care Unit	0	105	0.0
Surgical Intensive Care Unit	1	953	1.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

399

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

3

Total hours per week performing surveillance:

60

Total hours per week for infection control activities other than surveillance:

60

Spartanburg Hospital for Restorative Care

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

This type of facility does not perform surgical procedures.

Central Line Associated Blood Stream Infection (CLABSI) Rate; Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	3	751	4.0
Long Term Acute Care - Temporary Central Line	19	6349	3.0
Long Term Acute Care - Permanent Central Line	3	398	7.5

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

32

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

15

Total hours per week for infection control activities other than surveillance:

15

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Springs Memorial Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	63	0.00
	1	1	47	2.13
	2,3	*	14	*
Colon Surgery	0	*	1	*
	1	*	12	*
	2	*	17	*
	3	*	3	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	1	*	1	*
Hip Prosthesis (Replacement)	0	*	2	*
	1	0	21	0.00
	2,3	*	1	*
Abdominal Hysterectomy	0	0	49	0.00
	1	1	29	3.45
	2,3	*	4	*
Knee Prosthesis (Replacement)	0	*	5	*
	1	*	14	*
	2,3	*	6	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*
	1,2,3	*	5	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.

b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Springs Memorial Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	1206	0.8
Inpatient Rehabilitation Ward	0	280	0.0
All Inpatient Locations	3	1550	1.9

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

85

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

St. Francis - Downtown

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	0	*	2	*
	1	3	100	3.00
	2	4	224	1.79
Coronary Bypass Graft (Chest Only Incision)	0,1	*	4	*
	2,3	*	7	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	325	0.00
	1	1	303	0.33
	2,3	1	73	1.37
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	80	0.00
	1	1	112	0.89
	2,3	0	33	0.00
Hip Prosthesis (Replacement)	0	0	30	0.00
	1	1	78	1.28
	2,3	1	25	4.00
Knee Prosthesis (Replacement)	0	0	56	0.00
	1	0	52	0.00
	2,3	0	31	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

St. Francis - Downtown

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	3301	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

193

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

3

Total hours per week performing surveillance:

52

Total hours per week for infection control activities other than surveillance:

52

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

St. Francis - Eastside

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	18	*
	1	*	10	*
	2,3	*	5	*
Colon Surgery	1	*	4	*
	2	*	3	*
	3	*	1	*
Hip Prosthesis (Replacement)	0	1	145	0.69
	1	1	179	0.56
	2,3	3	38	7.89
Abdominal Hysterectomy	0	1	150	0.67
	1	3	146	2.05
	2,3	0	40	0.00
Knee Prosthesis (Replacement)	0	0	306	0.00
	1	2	438	0.46
	2,3	0	158	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	35	2.86
	1,2,3	0	51	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

St. Francis - Eastside

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
All Inpatient Locations	0	368	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

53

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Bon Secours - St. Francis Xavier Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	144	0.00
	1	0	83	0.00
	2,3	*	14	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	2	229	0.87
	1	0	158	0.00
	2,3	*	15	*
Hip Prosthesis (Replacement)	0	*	2	*
	1	2	24	8.33
	2,3	*	1	*
Abdominal Hysterectomy	0	2	165	1.21
	1	6	56	10.71
	2,3	*	2	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	59	1.69
	1,2,3	0	28	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Bon Secours - St. Francis Xavier Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	5	1805	2.8

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

95

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

30

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Summerville Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	1	193	0.52
	1	1	104	0.96
	2,3	*	6	*
Colon Surgery	0	0	29	0.00
	1	1	32	3.13
	2	*	4	*
Hip Prosthesis (Replacement)	0	0	22	0.00
	1	0	42	0.00
	2,3	*	15	*
Abdominal Hysterectomy	0	2	102	1.96
	1	1	43	2.33
	2,3	*	6	*
Knee Prosthesis (Replacement)	0	0	42	0.00
	1	0	65	0.00
	2,3	0	22	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	82	0.00
	1,2,3	0	27	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Summerville Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	1	923	1.1
All Inpatient Locations	2	2640	0.8

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

57

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

10

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Trident Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Coronary Bypass Graft (Chest and Donor Incision)	1	2	132	1.52
	2	0	73	0.00
Coronary Bypass Graft (Chest Only Incision)	0,1	*	1	*
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	1	186	0.54
	1	0	102	0.00
	2,3	*	12	*
Colon Surgery	0	*	10	*
	1	*	10	*
	2	*	2	*
	3	*	1	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	0	57	0.00
	1	0	52	0.00
	2,3	1	21	4.76
Hip Prosthesis (Replacement)	0	0	43	0.00
	1	2	89	2.25
	2,3	0	21	0.00
Abdominal Hysterectomy	0	1	153	0.65
	1	1	94	1.06
	2,3	0	25	0.00
Knee Prosthesis (Replacement)	0	0	40	0.00

Trident Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
	1	0	76	0.00
	2,3	*	12	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	1	37	2.70
	1,2,3	1	34	2.94

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Trident Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	22	4982	4.4

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

198

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

2

Total hours per week performing surveillance:

24

Total hours per week for infection control activities other than surveillance:

48

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Tuomey

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	145	0.00
	1	0	81	0.00
	2,3	*	8	*
Spinal Fusion (Data Collected: 12/01/2008 - 06/30/2009)	0	*	17	*
	1	0	25	0.00
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	*	15	*
	1	0	24	0.00
	2,3	*	11	*
Abdominal Hysterectomy	0	2	119	1.68
	1	0	21	0.00
	2,3	*	1	*
Knee Prosthesis (Replacement)	0	0	36	0.00
	1	2	93	2.15
	2,3	0	34	0.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	0	22	0.00
	1,2,3	*	3	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Tuomey

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	2	1754	1.1

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

189

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

10

Total hours per week for infection control activities other than surveillance:

32

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Upstate Carolina Medical Center

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	37	0.00
	1	*	16	*
	2,3	*	4	*
Colon Surgery	0	*	1	*
	1	*	15	*
	2	*	10	*
	3	*	3	*
Hip Prosthesis (Replacement)	0	*	5	*
	1	*	8	*
Abdominal Hysterectomy	0	*	3	*
	1	*	4	*
	2,3	*	1	*
Knee Prosthesis (Replacement)	0	*	17	*
	1	*	9	*
	2,3	*	1	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	6	*
	1,2,3	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Upstate Carolina Medical Center

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	349	0.0
All Inpatient Locations	0	708	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

43

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

20

Total hours per week for infection control activities other than surveillance:

20

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Village Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	7	*
	1	*	2	*
Colon Surgery	0	*	1	*
	1	*	1	*
Hip Prosthesis (Replacement)	0	*	3	*
	1	*	4	*
	2,3	*	3	*
Abdominal Hysterectomy	0	*	1	*
	1	*	1	*
Knee Prosthesis (Replacement)	0	1	21	4.76
	1	*	19	*
	2,3	*	4	*
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	3	*
	1,2,3	*	2	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Village Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	67	0.0
All Inpatient Locations	0	219	0.0

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Infection Control Process

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Waccamaw Community Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	32	0.00
	1	1	58	1.72
Colon Surgery	1	1	29	3.45
	2	*	12	*
Hip Prosthesis (Replacement)	0	*	10	*
	1	0	112	0.00
	2,3	*	11	*
Abdominal Hysterectomy	0	*	11	*
	1	*	18	*
	2,3	*	1	*
Knee Prosthesis (Replacement)	0	*	4	*
	1	1	185	0.54
	2,3	1	20	5.00
Vaginal Hysterectomy (Data Collected: 12/01/2008 - 06/30/2009)	0	*	18	*
	1,2,3	0	23	0.00

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Waccamaw Community Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical Intensive Care Unit	2	646	3.1
Inpatient Rehabilitation Ward	0	217	0.0
All Inpatient Locations	1	1372	0.7

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

97

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

34

Total hours per week for infection control activities other than surveillance:

30

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Wallace Thomson Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	0	23	0.00
	1	*	18	*
	2,3	*	2	*
Hip Prosthesis (Replacement)	0	*	1	*
	1	*	5	*
Abdominal Hysterectomy	0	*	4	*
	1	*	2	*
Knee Prosthesis (Replacement)	0	*	2	*
	2,3	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Wallace Thomson Hospital

Central Line Associated Blood Stream Infection (CLABSI)Rate

Data Collected: 12/01/2008 - 11/30/2009

Location[a]	No. of Infections	No. of Central Line Days[b,c]	Infection Rate (per 1000 Central Line Days)
Medical/Surgical Intensive Care Unit	0	130	0.0
All Inpatient Locations	1	453	2.2

a. The specific patient care area in which a patient is assigned while receiving care in the healthcare facility.
b. Central line days are the total number of days a central line is in place for all patients in selected hospital locations.
A central line day calculation example can be found in the Definitions of Terms.
c. * = Too few central line days. Reporting on too few central line days is a risk to confidentiality and data stability. If there are less than fifty central lined days, the rate and number of infections will be suppressed until there are more central line days to report.

Hospital Profile

Average Daily Census:

30

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

6

Total hours per week for infection control activities other than surveillance:

14

Healthcare Associated Infections Report - February 1, 2010

Reported by: South Carolina Department of Health and Enviromental Control

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Williamsburg Regional Hospital

Procedure	Risk Category[a,b,c]	No. of Infections	No. of Specific Procedures Performed[d]	Infection Rate (per 100 Procedures)
Cholecystectomy (Gallbladder Surgery - Data Collected: 12/01/2008 - 06/30/2009)	0	*	1	*

a. Basic SSI Risk Index: NHSN assigns surgical patients into risk categories based on the presence of one or more of three major risk factors. For further explanation see Definition of Terms.
b. If there is more than one risk category in a row (e.g., 2, 3), it means that the risk of infection between the individual categories was not different statistically, so the data from those categories shown were combined.
c. If you do not see a risk category, it means that no surgeries were performed for that particular risk category.
d. *= Too few procedures. Reporting on too few procedures is a risk to patient confidentiality and data stability. If less than twenty surgical procedures are performed, the rate and number of infections will be suppressed until more procedures are performed.

Williamsburg Regional Hospital

Central Line Associated Blood Stream Infection (CLABSI) Rate, Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

4

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

No

Infection Control Process

Number of Infection Control Practitioners:

1

Total hours per week performing surveillance:

28

Total hours per week for infection control activities other than surveillance:

8

Women's Center of Carolinas Hospital System, The

Reported by: South Carolina Department of Health and Enviromental Control

Healthcare Associated Infections Report - February 1, 2010

Surgical Site Infection (SSI) Rate by Procedure and Risk Index

Data Collected: 12/01/2008 - 11/30/2009

Procedures that are required to be reported were not performed at this hospital during this time period.

Central Line Associated Blood Stream Infection(CLABSI) Rate

Data Collected: 12/01/2008 - 11/30/2009

There were no central line days for this time period.

Hospital Profile

Average Daily Census:

10

Lab Capabilities: Does this hospital's laboratory use the Clinical and Laboratory Institute (CLSI) antimicrobial susceptibility standards?

Yes

Infection Control Process

Number of Infection Control Practitioners:

0.25

Total hours per week performing surveillance:

1.5

Total hours per week for infection control activities other than surveillance:

1.5

February 2010
Hospital Infections Disclosure Act (HIDA) Annual Report

SC Healthcare Associated Infection (HAI) Prevention Plan

Appendix G

D H E C
PROMOTE PROTECT PROSPER
South Carolina Department of Health and Environmental Control

South Carolina Healthcare Associated Infections (HAI) Prevention Plan
HAI Recovery Act

December 30, 2009

Approved by: C. Earl Hunter, Commissioner
South Carolina Department of Health and Environmental Control (DHEC)

Submitted to: US Department of Health and Human Services

For more information contact:
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South Carolina Healthcare Associate Infections (HAI) Prevention Action Plan

Introduction:

Background: In May 2006, the South Carolina Legislature passed the Hospital Infections Disclosure Act (**HIDA**), SC Code of Laws, Chapter 7 Article 20, requiring inpatient acute care hospitals to report to the South Carolina Department of Health and Environmental Control (**DHEC**) selected hospital acquired infections and selected infection prevention processes. Reporting began in July 2007 and in June 2008, HIDA was amended to allow reporting requirements to be phased in. DHEC and the HIDA Advisory Committee selected the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network **(NHSN)** as the HAI data reporting system. Over 65 hospitals were trained and enrolled in NHSN in March 2007 and began submitting reports on selected surgical site infections and central line associated bloodstream infections in critical care units on July 1, 2007. Since then, inpatient rehabilitation and long term acute care (LTAC) facilities have been added to the reporting system. Hospitals must submit reports every six months and DHEC must make these reports available to the public (www.dhec.sc.gov/hai).

DHEC has been awarded $201,000 by U.S. Department of Health and Human Services, Centers for Disease Control and Prevention **(CDC**), American Recovery and Reinvestment Act, Epidemiology and Laboratory Capacity for Infectious Diseases (ELC), Healthcare-Associated Infections - Building and Sustaining State Programs to Prevent Healthcare-associated Infections grant. Beginning in October 2009, and extending through 2011, these funds will be used to:

- fund a 0.50 FTE HAI Prevention Planning Coordinator (combined 0.25 FTE from Activity A -Planning and 0.25 FTE from Activity C – Collaboration)
- support training for public health staff to develop HAI prevention capacity (Surveillance, Collaboratives, Outbreak Investigations, Data – Outcome measures)
- support training for healthcare workers regarding best practices for surveillance and prevention through contracts for Activity B-Surveillance and Activity C-Collaboratives and hospital site visit support for new NHSN users.
- establish “contracted equivalent” support from the SCHA and ORS to support the HAI Planning Coordinator with logistical and operational support for planning and for the central line associated bloodstream infections (**CLABSI**) prevention collaborative.
- expand data for reports and outcome measures to include administrative claims data from the Office of Research and Statistics (**ORS**).

The following summary of assets provide the basic foundation for South Carolina’s public health infrastructure for HAI Prevention:
1) **HAI Surveillance Data**: The HIDA NHSN HAI Reports(www.dhec.sc.gov/hai) provide most of the data needed to measure the selected outcomes and prevention targets identified in the National HAI Prevention Action Plan. DHEC ensures the accuracy and completeness of the data through a defined validation program. Hospitals may also use these data for internal quality measures and to share with other facilities enrolled in prevention collaboratives. Additional data are available from ORS (e.g. *C. difficile*).

2) **HAI Core Public Health Staff for Surveillance and Public Reporting:** The Department of Health and Environmental Control (DHEC) has 2.5 state funded FTEs in the Bureau of Disease Control to implement HIDA. (One Epidemiologist, one Infection Preventionist, and ½ hourly position Program Manager.) Travel funds for hospital validation site visits are also budgeted. These resources are focused on surveillance and validation activities necessary to comply with HIDA. The DHEC Bureau of Health Regulations and the Legal Office staff are also participating in the planning process.

3) **Partnership Organization and Advisory Committee - South Carolina Alliance for Infection Prevention (SCHAIP):** During the process of working with the DHEC HIDA Advisory Committee, there were many discussions about the need to prevent infections, not just count them. Out of these discussions, the SC Hospital Association took the lead to form the South Carolina Alliance for Infection Prevention (**SCHAIP**) and, along with DHEC and APIC, brought the state partners together for the purpose of implementing a coordinated, effective approach to infection prevention initiatives in SC. This partnership serves as the multi-disciplinary advisory taskforce required for the HAI Prevention Plan. SCHAIP partners include SCHA, DHEC, APIC, HAI subject area experts, associations representing the continuum of care, state and federal agencies, and consumers. SCHAIP provides the statewide organizational foundation to coordinate, facilitate, and support the implementation of the HAI Prevention Plan in SC. Members also include representatives from Health Sciences South Carolina **(HSSC).** http://www.healthsciencessc.org/about/HSSCStratPlan10-15.pdf . *"Health Sciences South Carolina is a dynamic statewide collaborative of South Carolina universities and hospitals that seeks to improve the health and economic wellbeing of the state through advances in research, education and clinical care."* One of the HSSC projects is the establishment of the Healthcare Quality Trust (**HQT**) to focus on HAIs surveillance, laboratory capacity and outbreak detection and response, and prevention. HSSC members include the state's two Medical Schools, three research universities, and the four largest medical centers in the state.

While individual SCHAIP partners will be responsible to their funding sources for performance and outcomes, each will also work with SCHAIP to ensure collaboration, communication, and implementation of the state HAI Prevention Plan with the resources available.

4) SC has a community of highly knowledgeable, skilled, and committed healthcare professionals (physicians, nurses, laboratorians, etc.) working in infection prevention and epidemiology to provide the expertise needed to achieve the targeted reductions in HAIs.

The following summary of barriers and limitations may prevent planning and implementation:

1) Funding is severely limited by the recurring state budget reductions as revenues decline; SC received minimal funding from the ELC ARRA grant to expand to prevention.
2) Infection Prevention staffing shortages and high turnover
3) Lack of a structured, coordinated, and funded Infection Prevention Training Program to set priorities, target audiences, etc.

Planning Processes and Assumptions:

- The South Carolina HAI Plan action items are numbered in each of the four CDC Category Tables beginning with the number (1) one. (e.g. in Table # 1, Action Item 1.; In Table # 2. Action Item 1, Action Item 2., etc.)
- Plans were developed with input received from the South Carolina Healthcare Alliance for Infection Prevention (SCHAIP) HAI Planning Taskforce and with input from public health professionals within DHEC.
- The "Infrastructure" needed to establish an effective public health HAI prevention program includes:
  - public health staff and resources
  - strong partnerships and effective collaboratives
- The SCHAIP partners, committees, and workgroups will participate in identifying and prioritizing needs and resources and in implementing the plans.
- The HAI Plan describes a broad assessment and planning process in order for the SCHAIP partners to be ready to pursue and justify funding opportunities if they arise.
- Accountability will be defined in the planning process.
- Plan implementation and timelines are contingent upon maintaining existing resources and obtaining additional resources from state, federal, and /or private grant funds.
  - Implementation plans are designated as 1) implemented or planned with existing resources, or 2) planned - contingent upon new resources.
- DHEC Health Licensing has assessed the health facility regulations and has prioritized the hospital regulations as the first in line for revision. DHEC will obtain advice from the SCHAIP Laws and Regulations Committee subject area experts on HAI prevention best practices. Proposed regulations will be developed by DHEC with the final regulations contingent upon the established legislative process.
- Plans will also include proposed incentives, training, and workforce development for hospitals and, as resources develop, to expand across the continuum of care.
- DHEC will seek funds for public health resources through potential CDC grants and work with appropriate SCHAIP partners to seek funding through other available state, federal, and private grant resources.

South Carolina HAI Plan Template

1. Develop or Enhance HAI program infrastructure

Successful HAI prevention requires close integration and collaboration with state and local infection prevention activities and systems. Consistency and compatibility of HAI data collected across facilities will allow for greater success in reaching state and national goals. Please select areas for development or enhancement of state HAI surveillance, prevention and control efforts.

Table 1: State infrastructure planning for HAI surveillance, prevention and control.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
Level I			Establish statewide HAI prevention leadership through the formation of multidisciplinary group or state HAI advisory council i. Collaborate with local and regional partners (e.g., state hospital associations, professional societies for infection control and healthcare epidemiology, academic organizations, laboratorians and networks of acute care hospitals and long term care facilities (LTCFs)	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
	☒		**Action 1. Established the SC Healthcare Alliance for Infection Prevention (SCHAIP),** a formal SC HAI infrastructure organization and partnership to facilitate planning, development, and implementation of HAI prevention initiatives in SC. (Lead agencies and organizations are the SC Hospital Association (**SCHA**), SC Department of Health and Environmental Control **(DHEC**), the Association of Professionals in Infection Control and Epidemiology – Palmetto Chapter **(APIC-Palmetto**), and Health Sciences South Carolina's **(HSSC**) Healthcare Quality Trust **(HQT**). The SCHAIP steering committee agreed that SCHAIP would include the role of the HAI Prevention Plan Advisory Committee in its mission. Additional members / stakeholders were recruited to provide advice and to include representatives across the continuum of care, consumers, and relevant disciplines. **SCHAIP Goals include:** • Ensure coordination and communication between SCHAIP partners, including public health, to facilitate planning and implementation, define roles and identify resources, and prevent gaps and duplication of efforts and track projects and timelines. • Coordinate initiatives and facilitate consensus on issues related to infection prevention throughout the state. • Promote healthcare facility leadership support for infection prevention efforts and resources • Facilitate integration of infection prevention into education and training for all healthcare disciplines across the state. • Promote and develop a standardized statewide education program for IPs, and identify basic infection prevention educational	1. Re-organized to include HAI Plan Advisory Committee on 09-29-09 Convened first meeting on 10-21-09 and activities are ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
			resources for all healthcare workers. • Develop a mentoring program for Infection Preventionists. • Establish formal Implementation Committees or temporary Workgroups, as appropriate, to develop a plan, implement, and evaluate selected initiatives. Identify lead organization responsible for chairing the committees (e.g. APIC – Palmetto, Chairs the Training Committee). Define accountability. Existing committees: HAI Plan Taskforce, CLABSI Prevention Collaborative, Clean Hands Save Lives Collaborative, Training Committee. Planned committees: Laboratory Capacity, Laws / Regulations, Antimicrobial Stewardship) Convened HAI Planning meetings and developed the SC HAI Prevention Plan for submission to DHHS by 1-1-2010.	Ongoing and Committees to Report to the SCHAIP Meeting every other month on plans and progress .
			ii. Identify specific HAI prevention targets consistent with HHS priorities.	
	☒		**Action 2. Selected HAI Prevention Targets based upon SCHAIP input and existing data bases**: **a.** CLABSI 1 - Central Line Associated Bloodstream Infections - Reduce the CLABSI SIR by at least 50% from baseline or to zero in ICU and other locations. (CDC) Support for this selection is based upon the fact that hospitals are mandated to report CLABSIs to DHEC via the National Healthcare Safety Network (**NHSN**) and data are available beginning July 2007. HIDA reporting	2. a. CLABSI Target Selected with ongoing monitoring. (Implemented First Prevention Collaborative with face to face

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
		☒	requirements have been expanded beyond critical care to all locations. Also, a CLABSI Prevention Collaborative with 22 hospitals has been established by the SCHA funded by the Duke Endowment and with the participation from DHEC funded by ELC ARRA. (SC NHSN CLABSI Reports www.dhec.sc.gov/hai)	meeting / and training for facilities – organized and hosted by SCHA on 10-21-09)
		☒	**b. C diff 1.** *Clostridium difficile* – At least 30% reduction in hospitalizations with C. difficile per 1000 patient discharges. (AHRQ). Support for this selection is based upon the data availability from the Office of Research and Statistics. Future reporting of C.diff into NHSN is possible if prevention collaboratives select this method for outcome measures in addition to the administrative claims data, or if it is mandated for public reports in the future. Prevention collaboratives are being planned **contingent upon resources** for staff, travel, and training**.** South Carolina has developed an Antibiotic Resistance Strategic Plan and has many healthcare professional participants in the Carolinas Antimicrobial Stewardship Effort (CASE) who are interested in implementing prevention collaboratives if funding can be obtained for staff (ID physician and pharmacy consultants.)	---------- 2. b. C. diff. selected. (Prevention Collaborative Implementation contingent upon obtaining resources.)
		☒	**c. SSI 1.** Reduce the admission and readmission SSI SIR by at least 25% from baseline or to zero. Selection of this target is based upon the availability of SSI data for coronary artery bypass and hip and knee replacement surgeries as reported into NHSN since 2007 as mandated by the SC HIDA law. Also, reporting can be expanded to	---------- 2. c. SSI – selected (Implementation of an SSI Prevention Collaborative is

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 1. Develop or enhance HAI program Infrastructure.**	Target Dates for Implementation
			provide outcome measures for prevention collaboratives for other facilities across the continuum of care. SSI Prevention collaboratives are planned, **contingent upon receiving resources** for staff, travel, and training. SC NHSN SSI Reports www.dhec.sc.gov/hai	contingent upon obtaining resources.)
	☒		Establish an HAI surveillance, prevention and control program i. Designate a State HAI Prevention Coordinator **Action 3. Designated HAI Plan Coordinator (D.Roberts)**– 0.5 FTE funded from ELC ARRA. This was a full time state funded hourly position until state budget cuts reduced the funds for this position to 0.5. The duties included program management, facilitating the HIDA Advisory Committee, and implementing the mandatory HAI reporting law to include NHSN surveillance and public reporting. With the time limited ELC ARRA funds, the position was increased back to 1.0 with the new 0.5 FTE to be dedicated to the HAI Plan and participation with SCHA in the CLABSI prevention collaborative. ii. Develop dedicated, trained HAI staff with at least one FTE (*or contracted equivalent*) to oversee the four major HAI activity areas (Integration, Collaboration, and Capacity Building; Reporting, Detection, Response and Surveillance; Prevention; Evaluation, Oversight and Communication)	3. Implemented: 10-01-09
	☒		**Action 4. Maintain existing state funded Public Health Staff** Existing DHEC HAI staff includes 2.5 state funded FTEs (1.0 epidemiologist for 1 Infection Preventionist, 0.5 program manager) are assigned to HAI surveillance, NHSN data reports and public reporting,	4. State funds established in 2007 – with ongoing efforts

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
			and validation of HIDA mandated reporting requirements. Contracted services from the SCHA and Office of Research and Statistics provide for "contracted equivalents" to support the 0.5 FTE Planning Coordinator. **>Another state budget cut has been announced for early 2010 and the impact on this program is unknown at this time.**	to sustain funding; Expanding capacity for prevention and oversight are contingent upon additional resources.
		☒	**Action Planned 5. Identified additional public health staff needed to create a sustainable program and expand the HAI program to include new responsibilities for prevention, collaborations, outbreak investigations, etc.** Other public health staff were requested, but not funded, in the ELC ARRA grant to sustain and expand the HAI program to meet the needs identified in this HAI Planning Template and to expand prevention initiatives across the continuum of care. Staff is needed to manage the program including grant writing, budgets, supervise staff, and to participate in developing and maintaining state level partnerships. Knowledgeable staff is needed to implement prevention collaboratives, improve public health capacity to detect and investigate outbreaks, participate in HAI training, provide data analysis, interpretation, and dissemination for prevention quality measures; and to develop and provide HAI prevention subject area expertise for prevention collaboratives and activities. The following additional positions and resources are needed for public health to expand prevention beyond the current public reporting responsibilities and areas where other existing resources are designated in the plan: **a. HAI Program Manager -1.0 FTE**	---------- **5.** Expansion of HAI Program to include Prevention – Contingent upon new funding.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
			b. HAI Program Assistant- 1.0 FTE **c. HAI Epidemiologist– 1.0 FTE** **d. HAI Infection Preventionist -1.0 FTE.** **e. Travel, training, equipment and supplies.**	
			Integrate laboratory activities with HAI surveillance, prevention and control efforts. i. Improve laboratory capacity to confirm emerging resistance in HAI pathogens and perform typing where appropriate (e.g., outbreak investigation support, HL7 messaging of laboratory results)	
		☒	**Action 6. Develop HAI Prevention infrastructure / partnership described in Action 1.1 to facilitate and support the development of Laboratory capacity to support HAI Prevention, to confirm outbreaks and confirm emerging resistance.** The SCHAIP HAI Planning Taskforce identified a "desperate" need for laboratory capacity to support HAI prevention.	**6.** Planned contingent upon resources for lab capacity.
	☒		**Action 7. Identified current capacity and gaps from HSSC lab capacity survey.**	---------- 7. Completed ----------
		☒	**Action Planned 8. – Establish HAI Lab Capacity SCHAIP Workgroup to identify gaps, needs, and seek grant resources to provide for lab staff, equipment and supplies and address issues of scale, cost, contracts, and public health lab capacity.** Potential	**8.** Implement in 1st quarter of 2010 with Lab Workgroup

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 1. Develop or enhance HAI program Infrastructure.**	Target Dates for Implementation
			laboratory support will be established through the state Public Health Laboratory and/ or through one or more of the state's large Medical Center laboratories. It is recognized that to accomplish this goal, the SCHAIP partnership will work to create access to subject area experts from the large hospitals and academic medical centers. These will include hospital epidemiologists, infectious disease specialists, pharmacists, and laboratorians. The SCHAIP infrastructure will be developed to evaluate the proposals and to facilitate the process of obtaining resources and fully developing and integrating lab capacity into HAI surveillance, prevention, and control.	activities to be on going until resources identified and Lab Capacity established. ----------

		☒	**Action Plan 9. Develop and implement the SC HAI Lab Response Network to provide ongoing HAI lab capacity in SC. Work with SCHAIP partners including HSSC to develop.**
			Activities will include:
			• Establish and fund lab network with staff, equipment, supplies and data base (**contingent upon new resources**)
			  • Typing
			  – Pulse field gel electrophoresis (capability)
			  – Multi locus sequence typing (Mercedes)
			  – Multiple-locus-variable number tandem repeat analysis (MLVA)
			  • Sequencing
			  – bacteria/viruses (mycobacteria)
			  • Fill gaps in capacity:
			  • No lab is culturing C. difficile
			  • No lab is doing 16sRNA testing
			  • No phage typing at DHEC (CDC)
				9. Lab Network Implementation as soon as possible - contingent upon new resources
				---------- 	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
			• No antibiotic susceptibility in DHEC lab except mycobacteria	
Level II	☒		Improve coordination among government agencies or organizations that share responsibility for assuring or overseeing HAI surveillance, prevention and control (e.g., State Survey agencies, Communicable Disease Control, state licensing boards) **Action 10. Ensure state government agencies participation on HAI Planning Taskforce**	10. Established in the 4th quarter 2009 – to be ongoing.
		☒	**Action 11. Improve interagency and healthcare workers' understanding of state agencies HAI policies, procedures, and expectations.** • DHEC to develop and make available a short "one page" outline for health care facilities describing the role of each (Licensing, Certification, Disease Control) and how to contact and what to report to each. • Establish DHEC intra -agency procedures to ensure coordination for HAI surveillance, prevention, and control and appropriate sharing of information to detect, prevent, and control HAIs.	---------- 11. Implement in 3rd quarter 2010
	☒		**Action 12. Establish SCHAIP Laws and Regulations Committee with responsibility to:** • Review current HAI related licensing requirements for facilities • Review HAI related requirements for professional licensure.	12. Implement review in 1st quarter 2010 by HAI Laws /

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 1. Develop or enhance HAI program Infrastructure.**	Target Dates for Implementation
			• Include categories identified in the HAI National Action Plan and the CDC Planning Template. • DHEC Health Licensing created reference tables for existing laws and regulations for the purpose of discussion in the HAI Planning meetings.) • Identify infection prevention and other subject area experts to work with DHEC on the committee. • Identify pros and cons for the recommendations submitted to the HAI Planning Taskforce and others identified in the review process (e.g. mandatory infection control training and continuing education for professional licensure and mandatory infection prevention staffing standards for healthcare facilities). • Identify barriers to HAI Prevention (e.g. fire marshal's restrictions on location of Hand sanitizer) and plan for eliminating barriers. • DHEC will facilitate discussions with other state agencies responsible for professional licensure and certifications. • Present findings and proposals to the SCHAIP Committee.	Regulation Committee with activities to be on going. (Based upon legislative process and timeline, the <u>earliest</u> date to implement new Regulations will be June 2011 if there are no delays in the process.)
	Planned ☒		*Other:* **Action 13. Identify strategies, methods, and partners to provide incentives and support for healthcare facilities and health professionals to implement best practices and obtain training in infection surveillance, prevention and control. SCHAIP Planning Committee will:** • Identify pay for performance opportunities (e.g. Blue Cross/ Blue Shield) and develop plan to facilitate implementation. • Establish low cost, accessible training resources and disseminate information to Healthcare workers. <u>(Assigned to SCHAIP Training Committee)</u>	13. SCHAIP will develop Incentives strategies during 3rd Quarter 2010 with implementation contingent upon resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 1. Develop or enhance HAI program Infrastructure.	Target Dates for Implementation
			Facilitate use of standards-based formats (e.g., Clinical Document Architecture, electronic messages) by healthcare facilities for purposes of electronic reporting of HAI data. Providing technical assistance or other incentives for implementations of standards-based reporting can help develop capacity for HAI surveillance and other types of public health surveillance, such as for conditions deemed reportable to state and local health agencies using electronic laboratory reporting (ELR). Facilitating use of standards-based solutions for external reporting also can strengthen relationships between healthcare facilities and regional nodes of healthcare information, such as Regional Health Information Organizations. (RHIOs) and Health Information Exchanges (HIEs). These relationships, in turn, can yield broader benefits for public health by consolidating electronic reporting through regional nodes. **Action 14. Identify technical support needs and resources and define process to ensure coordination of information and opportunities.** Utilize SCHAIP Infrastructure and current Health Sciences South Carolina (HSSC) plans to improve IT resources for HAI surveillance and data sharing to coordinate needs assessment and to: • Identify and disseminate ways to promote electronic reporting standards – (e.g. HL-7 messages) • Identify working group or existing resource for information and coordination to support surveillance and data reporting IT needs. • Promote use of vendors to provide technical support for facilities that are NHSN users (e.g. to transfer lab data directly into NHSN) and to coordinate with other public health disease reporting systems. • Identify other agencies interested in this effort (e.g. Medicaid/	
		☒		Action 14. 3rd Quarter 2010.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 1. Develop or enhance HAI program Infrastructure.**	Target Dates for Implementation
			Medicare) to participate in Planning (participating in SCHAIP). • Define and train staff to use own data to identify clusters / outbreaks. (Include topic in Training Plan) • DHEC to improve ability to identify trends in routine reportable electronic (ELR) reporting of disease surveillance data system for pathogens potentially responsible for inpatient and outpatient HAIs.	
		☒	**Action 15**. Identify incentives to enable healthcare facilities to implement electronic reporting standards, to include lab and surgical data transmitted into NHSN. (e.g. funding for facilities to pay IT costs to program existing data systems to transmit data for surveillance and reporting.)	Action 15 Implementation Contingent upon finding resources to fund IT initiatives.
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

2. Surveillance, Detection, Reporting, and Response

Timely and accurate monitoring remains necessary to gauge progress towards HAI elimination. Public health surveillance has been defined as the ongoing, systematic collection, analysis, and interpretation of data essential to the planning, implementation, and evaluation of public health practice, and timely dissemination to those responsible for prevention and control.[1] Increased participation in systems such as the National Healthcare Safety Network (NHSN) has been demonstrated to promote HAI reduction. This, combined with improvements to simplify and enhance data collection, and improve dissemination of results to healthcare providers and the public are essential steps toward increasing HAI prevention capacity.

The HHS Action Plan identifies targets and metrics for five categories of HAIs and identified Ventilator-associated Pneumonia as an HAI under development for metrics and targets (Appendix 1):

- Central Line-associated Blood Stream Infections (CLABSI)
- *Clostridium difficile* Infections (CDI)
- Catheter-associated Urinary Tract Infections (CAUTI)
- Methicillin-resistant *Staphylococcus aureus* (MRSA) Infections
- Surgical Site Infections (SSI)
- Ventilator-associated Pneumonia (VAP)

Work is ongoing to identify optimal metrics and targets for VAP infection. However, detection and measurement with existing tools and methods can be combined with recognized prevention practices in states where an opportunity exists to pursue prevention activities on that topic.

State capacity for investigating and responding to outbreaks and emerging infections among patients and healthcare providers is central to HAI prevention. Investigation of outbreaks helps identify preventable causes of infections including issues with the improper use or handling of medical devices; contamination of medical products; and unsafe clinical practices. Please choose items to include in your plan at the planning levels desired.

[1] Thacker SB, Berkelman RL. Public health surveillance in the United States. Epidemiol Rev 1988;10:164-90.

Table 2: State planning for surveillance, detection, reporting, and response for HAIs

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
Level I			Improve HAI outbreak detection and investigation	
			iv. Work with partners including CSTE, CDC, state legislatures, and providers across the healthcare continuum to improve outbreak reporting to state health departments	
		☒	**Action 1.. Develop and disseminate clear reporting guidelines and definitions for HAI outbreaks.** (DHEC will lead process with existing staff and input from relevant SCHAIP members (e.g. APIC, ID Physicians).	1. 3rd Quarter 2010
			v. Establish protocols and provide training for health department staff to investigate outbreaks, clusters or unusual cases of HAIs.	
		☒	**Action 2. Identify HAI outbreak training goals and opportunities for DHEC staff.** DHEC has been funded by ELC ARRA for public health staff training.	2. Plan in 1st Quarter 2010 and ongoing as long as funding is available.
		☒	**Action 3. Define public health staff competencies, knowledge skills, and abilities needed to investigate HAI outbreaks.**	3. In 1st Quarter 2010.
			vi. Develop mechanisms to protect facility/provider/patient identity when	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
			investigating incidents and potential outbreaks during the initial evaluation phase where possible to promote reporting of outbreaks	
		☒	**Action 3 Define policies and procedures for reporting and consulting on HAI outbreaks between relevant state agencies. (DHEC - with existing staff.)**	3. 3rd Quarter 2010
			Action 4. Define policies and procedures for public release of information during initial phase of outbreak investigations. (DHEC - with existing staff.)	4. 3rd Quarter 2010
			vii. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms (MDRO), and other reportable HAIs)	
		☒	**Action 5. Train facility and healthcare staff to use own data to identify clusters / outbreaks. (Responsible: DHEC Infection Preventionist (IP) during hospital Validation site visits and SCHAIP Training Committee to include in the Training Plan.)**	**5. 1st Quarter 2011**
		☒	**Action 6. DHEC to develop routine automated surveillance data reports from the existing data base to identify trends in reportable disease surveillance system for pathogens potentially responsible for inpatient and outpatient HAIs.**	**6. 1st Quarter 2011**

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
			Enhance laboratory capacity for state and local detection and response to new and emerging HAI issues.	
		☒	**Action 7. Identify plan to submit and communicate lab data from existing resources**. **Define Lab capacity plan based on gaps and resources identified in the planning process (see Infrastructure Category).**	**7.** 1st Quarter 2010
		☒	**Action 8. Develop and implement the SC HAI Lab Response Network to provide ongoing HAI lab capacity in SC for HAI Outbreak detection and tracking.** Activities will include: • Establish and fund lab network with staff, equipment, supplies and data base to fill in the gaps in capacity (contingent upon new resources).	---------- 8**.** Contingent upon resources to establish HAI Lab Network.
Level II			Improve communication of HAI outbreaks and infection control breaches i. Develop standard reporting criteria including, number, size and type of HAI outbreak for health departments and CDC	
		☒	**Action 9. DHEC will develop HAI Outbreak policies and procedures to include:** • Communicate Outbreak prevention information rapidly	**9.** 1st Quarter 2011 (additional staff

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
			to facilities and, providers (including Infectious Disease physicians) via Health Advisories / Alerts. • Describe outbreak reporting and communication process • Disseminate targeted early warning data about unusual clusters via "be on the lookout" alerts and e-mails to facilities and providers. ii. Establish mechanisms or protocols for exchanging information about outbreaks or breaches among state and local governmental partners (e.g., State Survey agencies, Communicable Disease Control, state licensing boards)	will be needed to respond to increased expectations)
		☒	**Action 10**. **Define process for communicating information during outbreaks and breaches of practice standards between state partner agencies** (also responsibility for local implementation).	10. 1st Quarter 2011
	☒		Identify at least 2 priority prevention targets for surveillance in support of the HHS HAI Action Plan **Action 11**. **Priority Prevention surveillance: Central Line-associated Bloodstream Infections (CLABSI 1) - per 1000 device days by ICU and other locations**. • Stop BSI Collaborative – 22 hospitals enrolled at this time; 1st training provided 10-30-09 • Selection supported by the availability of active surveillance data reported into NHSN from medical – surgical ICUs since 2007 and the addition of reporting	11. Implemented data base in 2007. Selected targets 10-21-09.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
			requirements for all acute care locations in 2009.	
	☒		**Action 12**. **Priority Prevention surveillance: *Clostridium difficile* Infections (CDI)** – case rate per patient days from administrative /discharge data for ICD-9 CM coded C.diff infections. • CDI data available and selected for prevention target	12. Established SC baseline C. difficile administrative claims data report in 4th Quarter 2009.
	☐ ☒		**Action 13. Priority Prevention surveillance: Methicillin-resistant Staphylococcus aureus (MRSA) Infections** • Proposed - MRSA BSI lab data with match with hospital discharge data to assess if POA. (method being developed by DHEC – not in DHHS metric)	13. Proposed Pending validation of current method or new resources.
	☒		**Action 14**. **Priority Prevention surveillance: Surgical Site Infections (SSI)** • Deep incision and organ space infection rates using NHSN definitions. • Active SSI surveillance data reporting required in NHSN for all acute care hospitals for selected procedures in all hospitals where these procedures are performed (except where designated only for hospitals ≤ 200 beds). o Coronary Artery Bypass Graft (CBGB) (both chest and donor site incisions) o Coronary Artery Bypass Graft (CBGC) (with chest incision only) o Hysterectomy (abdominal - HYST) o Hip – prosthesis- (HPRO)	14. Established baseline data July 2007, Selected Targets 9-21-2009

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
	☐	☐	o Knee – prosthesis – (KPRO) o Colon (COLO) - (only report from hospitals of 200 beds or less)	
	☒ ☒		Adopt national standards for data and technology to track HAIs (e.g., NHSN). i. Develop metrics to measure progress towards national goals (align with targeted state goals). **Action 15. Adopted NHSN for mandatory HAI reporting in 2006. .** ii. Establish baseline measurements for prevention targets **Action 16. Baseline data for CLABSI and SSIs established and in NHSN.** Standardized Infection Rations (SIRs) will be used to measure trends over time. Administrative claims data report has been established for *C. difficile* baseline from data beginning 2008.	15. Implemented data collection 2007 and ongoing 16. Implemented and ongoing
			Develop state surveillance training competencies **i.** Conduct local training for appropriate use of surveillance systems (e.g., NHSN) including facility and group enrollment, data collection, management, and analysis	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.	Target Dates for Implementation
		☒	**Action 17. Surveillance training: Establish and implement a training session for NHSN Users in new facilities and newly hired IP and support staff in existing facilities using NHSN.** (Assigned to SCHAIP Training Committee for planning, with activities to be supported by partnership members as resources are identified. ELC ARRA Training funds will be available for Activity B and C through Contracts with the SCHA.) Training to include: • NHSN Enrollment • NHSN Training - Patient Safety Protocols • Case studies to ensure accurate application of surveillance case definitions. All inpatient acute care hospitals are using NHSN and staff were initially trained via two separate state wide trainings in February 2007 and April 2008 and conducted by the partnership with SCHA, APIC Palmetto, and DHEC. Ongoing training is needed to prepare new users as a result of high staff turnover in facilities.	17. Implement: 4th Quarter 2010
	☒		**Action 18. Establish the "Jump Start" Site Visits for facilities for new NHSN Users where no other NHSN users are on staff to provide mentoring and orientation.** DHEC IP visits new staff and APIC Palmetto developed references and resource notebooks for new IPs. (ELC ARRA funds are available for this project.)	18. Implemented 10-2009 and ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.	Target Dates for Implementation
	☒ Planned		**Action 19. Develop a plan to establish and combine resources for a formal HAI Training program in SC to ensure HAI surveillance, prevention, and control competencies in the healthcare workforce**. **SCHAIP will coordinate the planning process.** A lead organization will be identified and funding will be pursued through state, federal, and private grants. Limited ELC ARRA training funds are available for surveillance and the CLABSI prevention collaborative. a. The HAI Training program will: o Base the curriculum upon nationally (e.g. APIC) defined core competencies and content for: ▪ Infection Preventionists ▪ Basic HAI knowledge and skills needed by all healthcare professionals/ workers. ▪ Advanced HAI knowledge and skills needed by selected categories of healthcare professionals/ workers o identify competencies and rapidly ensure access to training for emerging infections. o establish recommendations for minimum standards for training and licensure o facilitate access to existing training resources to include access to low cost web based training o ensure access to high quality, advanced training	**19.** Planning to begin 1st Quarter 2010 with full implementation contingent upon resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.	Target Dates for Implementation
			and mentoring opportunities and case studies. o facilitate access to infectious disease and infection prevention professionals for consultation, training, and policy development. b. Identify state, federal, and private grant resources to establish the program from a partnership (SCHA, DHEC, AHEC, HSSC, APIC, etc…) c. Coordination assigned to the SCHAIP Training Committee with additional consultation from state and national professional groups.)	
	☒		**Action 20. Develop tailored reports of data analyses for state or region prepared by state personnel.** • Current HIDA reports are on DHEC website prepared by HIDA staff (www.scdhec.gov/hai) include CLABSI and SSI rates and SIRs. • Specific reports to measure the progress toward national targets will be developed from the data in the SC HIDA NHSN data base. • Evaluate data reports and develop additional reports as HAI Prevention initiatives are program funded.	20. Implemented: 2-8-08 and process of developing and evaluating reports is ongoing.
Level III	☒		**Action 21. Validate data entered into HAI surveillance (e.g., through healthcare records review, parallel database comparison) to measure accuracy and reliability of HAI data collection** • DHEC Infection Preventionist – began pilot validation protocol in March 2008. Revised protocol in March 2009.	21. Implemented March 2008 and process is ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
	☒ ☒ ☒ ☒ ☒ ☒		• Validation findings reported to HIDA Advisory Committee and presented to APIC Palmetto conference. • Developed a validation plan • Pilot test validation methods in a sample of healthcare facilities • Modify validation plan and methods in accordance with findings from pilot project • Implement validation plan and methods in all healthcare facilities participating in HAI surveillance • Analyze and report validation findings • Use validation findings to provide operational guidance for healthcare facilities that targets any data shortcomings detected	Completed Completed Completed Completed and ongoing. Completed and ongoing - annually. Process ongoing:
		☒	Develop preparedness plans for improved response to serious breaches in HAI prevention and control. i. Define processes and tiered response criteria to handle increased reports of serious infection control breaches (e.g., syringe reuse), suspect cases/clusters, and outbreaks **Action 22. Develop and include response procedures in DHEC HAI Outbreak protocols to include surveillance, detection, response, and reporting.** Additional DHEC resources defined in **Table 1.**	22. Develop procedures 2nd Quarter 2010.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.	Target Dates for Implementation
			Infrastructure - Action Plan are needed to expand activities for outbreak investigations in HC facilities.	Additional staff needed to implement.
		☒	Collaborate with professional licensing organizations to identify and investigate complaints related to provider infection control practice in non-hospital settings, and to set standards for continuing education and training. **Action 23. Facilitate a meeting with health professional licensing organizations to discuss:** • Developing formal protocols for complaint investigation • Establishing minimum standards or guidelines for training and licensure • Including all healthcare workers, plus those in non-hospital settings in the Training competencies and needs.	23. By 3rd Quarter 2010.
			Adopt integration and interoperability standards for HAI information systems and data sources i. Improve overall use of surveillance data to identify and prevent HAI outbreaks or transmission in HC settings (e.g., hepatitis B, hepatitis C, multi-drug resistant organisms (MDRO), and other reportable HAIs) across the spectrum of inpatient and outpatient healthcare settings	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
	☒		**Action 24. DHEC uses CDC NBS system for Public Health Surveillance and has implemented Electronic Lab Reporting (ELR) from clinical labs.** • DHEC has encouraged hospitals to use standardized HL-7 messaging and electronic download of lab and surgical data into NHSN to reduce the burden of reporting. Future activities will depend upon technical guidance from CDC and incentives for healthcare facilities and vendors. ii. Promote definitional alignment and data element standardization needed to link HAI data across the nation.	24. Implemented and ongoing; additional guidance is needed if public health is to facilitate intra hospital IT standards.
	☒		**Action 25. SC DHEC selected NHSN with standardized definitions for the mandatory reporting data base.** To the extent knowledge and resources are available, we will continue to promote this effort.	25. Ongoing
	☒		Enhance electronic reporting and information technology for healthcare facilities to reduce reporting burden and increase timeliness, efficiency, comprehensiveness, and reliability of the data i. Report HAI data to the public **Action 26. SSI and CLABSI reporting into NHSN began in July 2007 with the first public report posted in February 2008 and every 6 months after.**	26. Completed and ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) **Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.**	Target Dates for Implementation
	☒		Make available risk-adjusted HAI data that enables state agencies to make comparisons between hospitals. **Action 27. DHEC reported the first Hospital Compare report using Standardized Infection Ratios (SIRs) in February 2009**.	27. Completed and ongoing – annually since Feb. 2008.
		☒	Enhance surveillance and detection of HAIs in nonhospital settings **Action 28. Develop automated reports as described in the Table 2 Surveillance template and validate reports**. Routine reporting of outbreaks and specified notifiable conditions is required by DHEC from all hospitals, labs, and physicians. However, HAI outbreaks are not readily apparent from the facility type in the routine case reporting data base and trend data from labs may not be analyzed by ordering practice.	3rd Quarter 2011. ---------- 28. Contingent upon resources are to develop the data reports.
		☒	**Action 29. The following actions will be promoted by DHEC for outbreak detection and education**: • Continue annual notification of Non-hospital settings to promote reporting of potential HAIs that are on the list of reportable conditions (e.g. Hepatitis B and C) • Encourage healthcare workers from non-hospital settings to participate in HAI educational opportunities. (Include these non-hospital workers in the Training Plan. • Implement reporting and response protocols for	29. Planned contingent upon resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 2. Planning for Surveillance, Detection, Reporting and Response for HAIs.	Target Dates for Implementation
			outbreaks • Promote SSI – post discharge surveillance reporting • Identify options to link professional credentials and re-licensure to education and training for the Training and Laws and Regulations Committee.	

3. Prevention

State implementation of HHS Healthcare Infection Control Practices Advisory Committee (HICPAC) recommendations is a critical step towards the elimination of HAIs. CDC with HICPAC has developed evidence-based HAI prevention guidelines cited in the HHS Action Plan for implementation. These guidelines are translated into practice and implemented by multiple groups in hospital settings for the prevention of HAIs. CDC guidelines have also served as the basis the Centers for Medicare and Medicaid Services (CMS) Surgical Care Improvement Project. These evidence-based recommendations have also been incorporated into Joint Commission standards for accreditation of U.S. hospitals and have been endorsed by the National Quality Forum. Please select areas for development or enhancement of state HAI prevention efforts.

Table 3: State planning for HAI prevention activities

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
Level I			Implement HICPAC recommendations. i. Develop strategies for implementation of HICPAC recommendations for at least 2 prevention targets specified by the state multidisciplinary group.	

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
		☒	**Action 1. Prevention Target – reduce hospitalizations with C. difficile:** a. Reconvene the SC APIC / DHEC Antibiotic Resistance Workgroup and additional partners (e.g. Health Licensing, Infectious disease physicians) under the new SCHAIP Infrastructure to: • Update the 2007 SC Antibiotic Resistant Organisms Strategic Plan • Revise 1998 "SC Guidelines for Prevention and Control of Antibiotic Resistant Organisms in Healthcare Settings" to include guidance from the HICPAC MDRO Guidelines in Healthcare Settings, 2006. • Include HICPAC and other nationally accepted HAI Prevention guidance for discussion during the planned revisions of the HAI related Health Regulations. b. Identify opportunities to fund and implement at least one Antimicrobial Stewardship Prevention Collaborative. c. Include topics on Antibiotic Resistance in HC Settings and HICPAC Guidelines in the HAI training plan.	1. Continue Planning with Implementation contingent upon resources. Target: 4th Quarter 2010.
		☒	**Action 2. Prevention Target: SSI 1 – Reduce the admission and readmission SSI SIR by at least 25% from baseline or to zero.** a. Include HICPAC Recommendations and other Safe Surgery recommendations for SSI Prevention in the HAI Training Plan. b. Identify opportunities to fund and implement an SSI Prevention collaborative.	**2**. Implement SSI training based on Training Plan and resources - Prevention Collaborative contingent upon resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
	☒ Planned		*Other:* **Action 3. Define SCHAIP process for a timely review of all future new or revised HICPAC Guidelines and develop an implementation plans.** a. For each new or revised HICPAC guideline, establish a SCHAIP workgroup and implementation plan to include alerting Healthcare Facilities of the new guidelines, identifying training needs, performance indicators, and policy implications.	3. 2nd Quarter 2011.
	☒		Establish a prevention working group under the state HAI advisory council to coordinate state HAI collaboratives i. Assemble expertise to consult, advise, and coach inpatient healthcare facilities involved in HAI prevention collaboratives **Action 4. The SC Healthcare Alliance for Infection Prevention (SCHAIP) will identify a specific Collaborative Workgroup for each collaborative to include subject area experts.** Experts are accessible, however each collaborative will need funding to support staff time. A **STOP BSI Collaborative Workgroup is functioning now for the CLABSI Prevention Collaborative.**	**Action 4.** STOP BSI workgroup was established in 2009 and a Workgroup will be established, for each collaborative when resources are available. Access to subject area experts contingent upon resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
	☒		Establish HAI collaboratives with at least 10 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions) **Action 5. a. CLABSI – "STOP BSI" Prevention established with 22 hospitals.** The STOP BSI working group is in place to consult, advise and coach the facilities currently enrolled in the CLABSI Prevention Collaborative, funded by the Duke Endowment and limited DHEC participation funded by ELC ARRA. The first face to face training was held on 10-30-09.	5. a. Implemented 2009 and ongoing.
		☒	**Action 5.b**. **Establish a prevention working group for C.diff and / or SSIs if resources are obtained to implement the prevention collaborative.**	5. b. Expanding Collaboratives - contingent upon resources.
	☒		i. Identify staff trained in project coordination, infection control, and collaborative coordination	Implemented CLABSI - 2009 and ongoing.
	☒		ii. Develop a communication strategy to facilitate peer-to-peer learning and sharing of best practices	Implemented CLABSI - 2009 and ongoing.
	☒		iii. Establish and adhere to feedback of a clear and standardized outcome data to track progress	Implemented CLABSI - 2009 and ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
			Develop state HAI prevention training competencies i. Consider establishing requirements for education and training of healthcare professionals in HAI prevention (e.g., certification requirements, public education campaigns and targeted provider education) or work with healthcare partners to establish best practices for training and certification	
		☒	**Action 6**. **DHEC and SCHAIP Training Committee will facilitate discussion to establish training competencies / requirements and identify incentives and best practices for training and certification for HAI prevention** to include many partners in the process (DHEC, SCHA - Duke Endowment, AHEC, Professional Licensing Boards, Academic Medical Centers, DHHS, Colleges of Nursing and Medicine, Rural Health)	6. 1st Quarter 2011
Level II			Implement strategies for compliance to promote adherence to HICPAC recommendations i. Consider developing statutory or regulatory standards for healthcare infection control and prevention or work with healthcare partners to establish best practices to ensure adherence	
		☒	**Action 7. Identify regulatory strategies to ensure best practices in Laws/ Regulations Committee established by SCHAIP to provide consultation to Health Licensing during the Hospital Regulations Review planned for 1st Quarter 2010**.	7. Discussions to begin 1st Quarter 2010 and ongoing.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
		☒	**Action 8. Include incentives and educational strategies to promote adherence to HICPAC standards and other best practices**.	8. Discussions to begin 1st Quarter 2010 and ongoing.
			ii. Coordinate/liaise with regulation and oversight activities such as inpatient or outpatient facility licensing/accrediting bodies and professional licensing organizations to prevent HAIs	
		☒	**Action 9. SCHAIP Legal/ Regulations Committee to identify and address barriers to implementing standards and guidelines**. (e.g. hand hygiene dispensers – fire; infectious wastes). (reference guidelines)	**9.** Discussions to begin 1st Quarter 2010 and ongoing until barriers resolved..
		☒	**Action 10. Review of laws and regulations and incentives to include facilitated discussion of recommendations submitted during the SCHAIP Taskforce meetings.** • Consider including establishing minimum requirements for: a) hospitals to have a minimum # of Infection Preventionist FTEs / 100 beds in healthcare facilities, b) include other IP responsibilities such as additional outpatient practices, long term care, and environmental in the minimum FTE calculation, c) consider other measurements (e.g. adjusted pt. volume), d) consider available IP work force	**10**. Begin review of Hospital Regulations 1st Quarter 2010 with existing resources.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
			• Consider establishing statewide guidelines or recommendations instead of "requirements" as a minimum (e.g. identify incentives such as HIDA recognition for high level of performance (set of minimum performance measures to include staffing +)	Begin review of Incentives with SCHAIP Taskforce.
			iii. Improve regulatory oversight of hospitals, enhancing surveyor training and tools, and adding sources and uses of infection control data	
		☒	**Action 11. DHEC will work with SCHAIP committee to identify "basic infection control 101" training needs for facility surveyors to be able to identify breeches in infection control.**	11. Include in training plan and contingent upon resources
			iv. Consider expanding regulation and oversight activities to currently unregulated settings where healthcare is delivered or work with healthcare partners to establish best practices to ensure adherence.	
			(Planning for expanding oversight to unregulated settings is not feasible at this time. There is no legal authority and current staffing for the regulated facilities is very limited and more budget cuts have been announced.)	Contingent upon resources
			Other	
		☒	**Action 12. HAI Prevention Best Practices will be encouraged for all healthcare workers/ providers through educational efforts promoted by SCHAIP**. Information on low cost web based courses and other training opportunities will be promoted by SCHAIP to appropriate audiences.	12. Include in training plan.

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 3: Prevention	Target Dates for Implementation
		☐	Enhance prevention infrastructure by increasing joint collaboratives with at least 20 hospitals (i.e. this may require a multi-state or regional collaborative in low population density regions) **See proposed prevention collaboratives for C.diff and SSI - Pending additional resources**.	**Pending additional resources**.
		☐	Establish collaborative to prevent HAIs in nonhospital settings (e.g., long term care, dialysis)	**Pending additional resources**.
Please also describe any additional activities, not listed above, that your state plans to undertake. Please include target dates for any new activities.				

4. Evaluation and Communications

Program evaluation is an essential organizational practice in public health. Continuous evaluation and communication of practice findings integrates science as a basis for decision-making and action for the prevention of HAIs. Evaluation and communication allows for learning and ongoing improvement to occur. Routine, practical evaluations can inform strategies for the prevention and control of HAIs. Please select areas for development or enhancement of state HAI prevention efforts.

Table 4: State HAI communication and evaluation planning

Planning Level	Check Items Underway	Check Items Planned	Items Planned for Implementation (or currently underway) Table 4. Evaluation and Communications	Target Dates for Implementation
Level I			Conduct needs assessment and/or evaluation of the state HAI program to learn how to increase impact i. Establish evaluation activity to measure progress towards targets and	
		☒	**Action 1. Establish DHEC Tracking Table to identify responsibilities of Divisions and timelines**.	1. 1st Quarter 2010
		☒	**Action 2. Establish SCHAIP Organizational Chart and Tracking Table to identify plans, responsibilities, time lines and document progress toward goals and targets.**	2. 1st Quarter 2010
			ii. Establish systems for refining approaches based on data gathered	3. 1st Quarter 2010
		☒	**Action 3. Tracking system will include outcome measures and data documenting progress toward targets**. Committees to report progress to SCHAIP meeting every other month, or as otherwise designated, and include evaluation and revised plans and strategies as needed. .	
		☒	**Action 4. Develop and implement a SCHAIP communication plan** for the state's HAI program to meet public and stakeholder's needs. Include state priorities for HAI prevention to healthcare	4. 2nd Quarter 2010

	☐	☐	organizations, professional provider organizations, governmental agencies, non-profit public health organizations, and the public.	
Level II	☒		Provide consumers access to useful healthcare quality measures **Action 5**. **Continue public reporting of selected HAIs** • Develop Healthcare Quality Reports to include Prevention Initiatives. • Develop Objectively measured recognition program – consistent with guidelines. (contingent upon receiving additional public health resources for subject area expertise)	5. 2nd Quarter 2011 (expanding beyond mandatory reporting is contingent upon receiving additional resources)
Level III	☒		Identify priorities and provide input to partners to help guide patient safety initiatives and research aimed at reducing HAIs **Action 6. Establish SCHAIP priorities for initiatives and research.** SCHAIP Infrastructure partners and committees are keys to establishing effective communications and feedback between partners to accomplish this goal. DHEC has an established HAI surveillance, validation, and public reporting program using NHSN standards. HSSC is the lead in HAI research, SCHA has a strong patient safety and quality program, APIC Palmetto has a long history of providing infection prevention education and mentoring for IPs. • SCHAIP process to recommend priorities and propose prevention initiatives and research.	6. By 3rd Quarter 2010, complete formal plan