



Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC and Connecticut Department of Public Health priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. Where SIR and comparison is not available from CDC's National Healthcare Safety network (NHSN), rates per 100,000 patient days are given. The infection data are reported to NHSN and analyzed by the CT DPH.

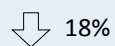
This report is based on 2015 data.

CLABSI

SIR = 0.20

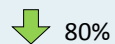
CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.



18%

Facility SIR was than the statewide 2015 SIR of 0.38 (but not statistically significantly)



80%

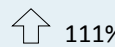
Facility SIR was statistically significantly lower than the national baseline SIR of 1.0

CAUTI

SIR = 2.61

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.



111%

Facility SIR was higher than the statewide 2015 SIR of 1.50 (but not statistically significantly)



161%

Facility SIR was statistically significantly higher than the national baseline SIR of 1.0

MRSA Bacteremia

LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacterium usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections

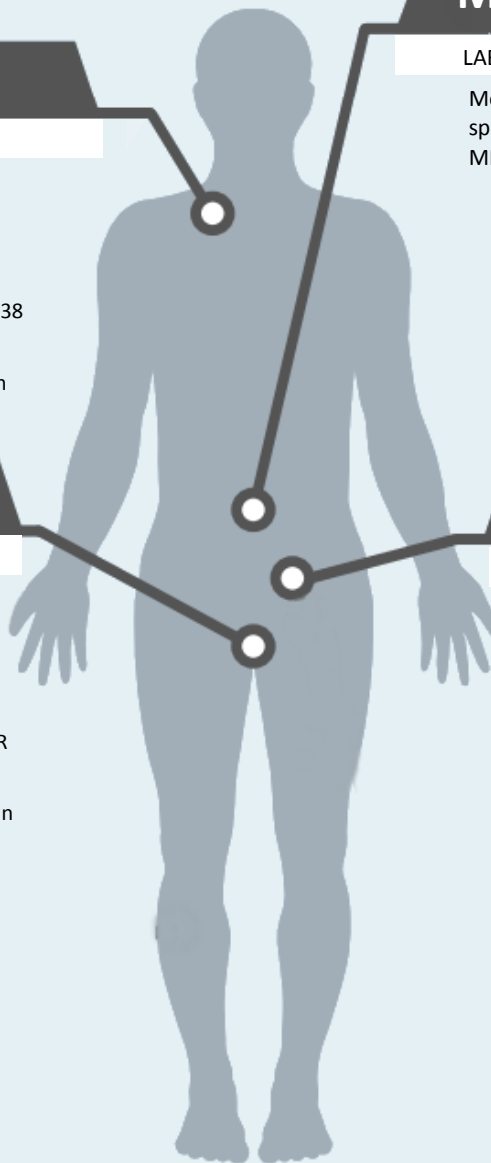
Rate = 0.83/10,000 patient days

C. difficile Infections

LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are damaged for up to months. During this time, patients can get sick from *Clostridium difficile*, bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Rate = 0.69/10,000 patient days





HAI REPORT 2015

HOSPITAL FOR SPECIAL CARE



WHAT IS THE STANDARDIZED INFECTION RATIO?

The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

WHAT DO THE PERCENTAGES MEAN?

The percentage next to each arrow shows the amount the facility's SIR differs from the national baseline SIR of 1.0, or the amount it differs from the statewide SIR for that HAI in given type of unit in 2015.

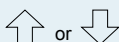
LEGEND



2015 facility SIR is significantly lower (better) than comparison group (state or national baseline)



2015 facility SIR is significantly higher (worse) than comparison group (state or national baseline)



2015 facility SIR is not statistically significantly different from comparison group; arrow direction indicates if SIR is more or less than comparison group



2015 facility SIR cannot be calculated

Statewide 2015 SIRs	
CLABSI	0.38
Adult ICUs	0.54
Adult Wards	0.25
Pediatric Wards	—
CAUTI	1.50
Adult ICUs	1.51
Adult Wards	1.49
MRSA	
0.75/10,000 patient days	
CDI	
2.19/10,000 patient days	

HAI type	Unit type	Device days, number of procedures, or patient days	Observed infections	Predicted infections	SIR	95%CI	How does this facility compare?	
							State (2015)	National baseline
CLABSI	Adult ICUs	2,101	1	2.73	0.37	(0.02, 1.81)	↓ 17%	↓ 63%
	Adult Wards	7,887	1	7.10	0.14	(0.01, 0.70)	↓ 11%	↓ 86%
	Pediatric Wards	58	0	0.05				
CAUTI	Adult ICUs	869	9	2.17	4.14	(2.02, 7.60)	↑ 263%	↑ 314%
	Adult Wards	3,905	17	7.81	2.18	(1.31, 3.41)	↑ 69%	↑ 118%

HAI type	Patient days	Observed events	Rate (observed events per 10,000 patient days)
MRSA events	72,507	6	0.83
CDI events	72,597	5	0.69

* No SIR or national comparison was available from the NHSN at the time of publication; therefore, facility rates are presented instead.

FACILITY PROFILE

Number of staffed beds	Full time infection preventionists (40hr/wk)	Beds/full-time IP
228	1.0	228