Executive summary 2015

Health care-associated infections in Oregon hospitals

Health care-associated infections (HAIs) can have devastating consequences for patients. The summary below shows how 2015 data from Oregon's acute care hospitals compares to: 1) national baselines and 2) 2013 national HAI reduction targets set by the U.S. Department of Health and Human Services (HHS).



CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS 12 INFECTIONS

▼ Better than 2006–08 national baseline

hospitals \(\times \) Did not meet 2013 HHS target

CLABSI in adult and pediatric ICUs*

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS 50 INFECTIONS

▼ Statistically better than 2006–08 national baseline

hospitals • Met 2013 HHS target

CLABSI in adult and pediatric wards*

CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS 68 INFECTIONS

▼ Statistically better than 2006–08 national baseline

hospitals \(\times \) Did not meet 2013 HHS target

MRSA bloodstream infections (MRSA BSIs)†

HOSPITAL-ONSET MRSA BSI

51 INFECTIONS

▼ Statistically better than 2010–11 national baseline

hospitals Met 2013 HHS target

C. Difficile infections ‡

HOSPITAL-ONSET C. DIFFICILE

909 INFECTIONS

▼ Statistically better than 2010–11 national baseline

hospitals | X Did not meet 2013 HHS target

CAUTI in adult and pediatric ICUs §

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

117 INFECTIONS

▼ Statistically better than 2009 national baseline

hospitals *Met 2013 HHS target*

CAUTI in adult and pediatric wards §

CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

71 INFECTIONS

hospitals (

V Statistically better than 2009 national baseline

✓ Met 2013 HHS target

*A CLABSI occurs when germs enter the blood along a tube (central line) placed in a large vein.

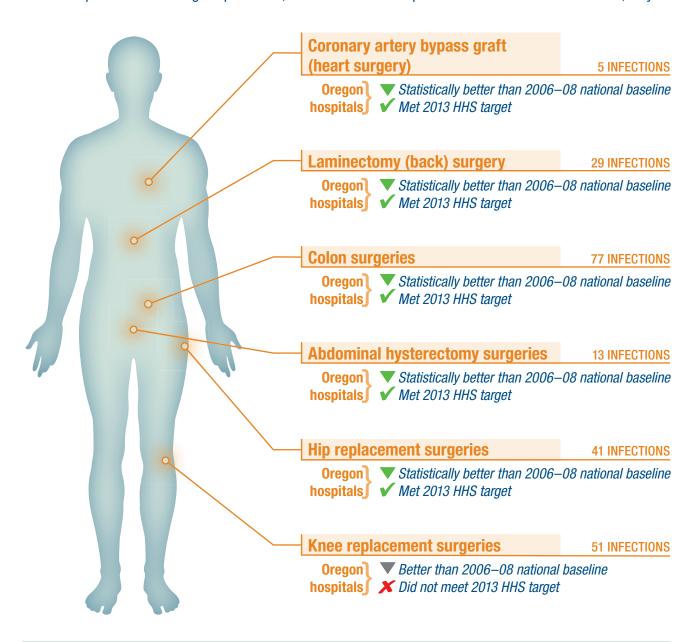
†An MRSA BSI is a difficult to treat infection caused by germs that enter the body through wounds or medical devices.

‡ *C. difficile* spreads to patients from unclean hands and surfaces in hospitals, leading to colon infection

§ CAUTIS occur when germs travel up a urinary catheter that was not put in correctly, not kept clean, or left in too long.

SSIs surgical site infections

A surgical site infection (SSI) occurs when germs enter a surgical wound during or after surgery. The data below are for deep incisional and organ space SSIs, which are detected upon index admission or readmission, only.



THE TAKE AWAY

In 2015, Oregon hospitals continued to reduce CLABSIs in adult and pediatric ICUs, but were unable to meet national prevention targets in NICU and ward settings. On CAUTI infections, Oregon hospitals performed favorably compared to national performance at baseline and currently. Prevention of hospital-onset *C. difficile* infections worsened in 2015.

Oregon hospitals performed better than hospitals nationally in terms of preventing SSIs following heart, hysterectomy, hip and colon surgeries. Performance was less impressive for laminectomy and knee surgeries, and Oregon hospitals did not meet the HHS reduction target for SSIs following knee surgeries.

LEGEND

Statistically fewer infections

Fewer infections (not statistically significant)

▲ More infections (not statistically significant)

▲ Statistically more infections

✓ Met target

X Did not meet target