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Infection data helped Swedish clean up its act

State now lists infection rates of hospitals on Web site

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The state aired the dirty laundry, or shall we say the infected laundry, of certain hospitals on Wednesday. And there were some surprises when the Washington State Department of Health went live shortly before noon with [its long-awaited Web site](#) revealing the infection rates for hospitals statewide.

The biggest shock involved Swedish Medical Center, one of the state's biggest and most prominent hospitals. Swedish was listed as one of only two hospitals in the state with unusually high infection rates caused by tubes known as "central lines" that are inserted into patients. The other outlier for those kinds of infections was Grays Harbor Community Hospital in Aberdeen.

But before you pull Aunt Astrid out of Seattle's Swedish, or move away from Grays Harbor County altogether, you need to know more details. There's also good news in all of this -- including good news for the patients at Swedish and Grays Harbor hospitals.

Updated data show both hospitals made significant reductions in central-line infections after the time period when the Web site data was generated, which was July 2008 through June 2009. According to hospital staffs, those improvements are a result of intense internal investigations and changes that were made possible in part because of the availability of this kind of data.

The state's new Web site was mandated by law in 2007, and has been a project of a small staff of health department data experts ever since. Though it includes and emphasizes information on infection prevention, it is imperfect and not entirely user-friendly, according to at least one prominent activist who reviewed it after it went live.

The Web site is a "modest effort," said Betsy McCaughey, founder and chairman of the Committee to Reduce Infection Deaths. However, she added that it is also a "very, very important development" in the world of infection reporting.

Twenty-six states, including Washington, now require hospitals to report infections that occur in their institutions. In widely varying degrees, most of those states make the data available to the public.

McCaughey and one of her staff members applauded the state for publishing the Web site though they felt it required viewers to take too many steps (cross-referencing material) to understand the data.

The Washington Web site is also incomplete. Missing are data on surgical-site infections, which was also mandated by law. The requirement for hospitals to report surgical-site infections went into effect only this month. That data will be available publicly "sometime in 2011," said David Birnbaum, program manager for the state's healthcare-associated infections program.

The only other type of infection rate available on the site -- besides central lines -- involves a sometimes-deadly problem known as ventilator-associated pneumonia. These are cases where patients who cannot breathe on their own contract pneumonia because of infections caused by contamination around the ventilators pumping air into their lungs.

The Web site identified seven hospitals with unusually high rates of ventilator-associated pneumonia during a six-month reporting period of January through June 2009. They were Mary Bridge Children's Hospital in Tacoma, Harrison Medical Center in Kitsap County, Highline Medical Center in Burien, PeaceHealth Saint John Medical Center in Longview, Providence Saint Mary Medical Center in Walla Walla, Saint Clare Hospital in Lakewood and Yakima Regional Medical and Cardiac Center in Yakima. Staff that could be reached at those hospitals reported improvements since the data were collected.

The data are self reported and there is no penalty in the reporting law for misleading the state or failing to report. However, the state could take action against a violator through its hospital licensing operations. The health department is working on an audit program that will allow it to check compliance, said Pam Lovinger, a health department official who oversees the reporting program. When the state is able, it will, among other things, have an official go into the field and spot-check hospital charts. One problem, however, is a very small staff, said Birnbaum.

"We've had no issue with a hospital refusing to report," said Lovinger, senior advisor for policy and business practices at the health department's division of epidemiology, health statistics and public health laboratories.

Hospital-acquired infections kill as many as 90,000 people nationwide, according to studies. A similar number are killed annually because of other types of medical errors. Reporting of medical errors and infections has been an issue since the death rate was revealed in a major federal report a decade ago. Congress and the federal government have resisted national reporting of medical errors. Washington requires reporting of medical errors, but a recent Hearst Newspapers investigation revealed compliance is low. Congress is apparently taking steps this year to require infection reporting nationwide.

Hospital officials who were interviewed yesterday welcomed the state's reporting requirements, and the health department's new Web site. Experiences related at three

institutions -- Swedish, Gig Harbor and PeaceHealth Saint Joseph Hospital -- underscored the value of collecting infection data.

Dr. Curtis Veal, medical director of critical care at Swedish, said he and his staff started noticing in the data an "uptick" in central-lines infections in the latter part of 2008. Central lines are tubes inserted into the neck, chest, arm or leg that are used to send fluids or drugs into the body, usually into the area near the heart, or to take blood samples or monitor artery pressure. Without precautions, they can easily become infected. Swedish staff began "drilling down" into their operations to find the problem, said Veal, who oversees all the intensive care units in the massive Swedish system. It turned out the problem was administrative. They found there had been staffing changes in the team that installs intravenous lines, he said. There were breakdowns in procedures and failures when patients were "handed off" from one caretaker to another. Changes were made, including more frequent "painting" of patients with antiseptics. The infection rate has dropped threefold, he said.

Linda Brown, hospital spokeswoman at Grays Harbor, said its staff also investigated a mid-year 2009 spike in central-lines infections and came up with a simple solution. A combination of a mandatory checklist and the universal use of a package of sterilizing equipment for every procedure has cut its central-lines infection rate to zero, she said.

Angie Dickson, infection preventionist at St. John Medical Center in Longview, found an even simpler solution through an incredible discovery at her hospital. Alarmed by a spike in ventilator-associated pneumonias in late 2008, her staff "went back to basics" checking how everyone was following instructions. When it appeared they were doing as told, "we did more digging," she said. That's when they found that a sodium bicarbonate coating on the swabs used to apply antiseptic to the mouths of ventilator patients was actually "rendering the antiseptic ineffective." As soon as the swabs were changed, and after they doubled the number of times they clean a patient's mouth, the pneumonia rate fell. "We have not had a ventilator-associated pneumonia since Nov. 1, 2009," she said.

For these kinds of reasons and more, hospital officials and patient-safety experts at the Washington State Hospital Association have become fans of infection-data collecting. The Washington State Hospital Association and its member institutions have an "audacious goal" of cutting hospital-acquired infections to zero by 2012, said WSHA spokeswoman Beth Zbrorowski. The data released yesterday indicate they have a way to go.

It appears that public reporting of infection-rate data may help that cause. Grays Harbor Community -- the only hospital serving that area for about 60 miles -- has been posting its infection rates on its public Web site since July 2008, which is highly unusual for any hospital in the country. Its failures were there for anyone to see, and that kind of transparency helps the hospital strive for perfection, Brown said. "We are very excited that the state is posting these infection rates, and that hospitals are becoming more transparent," said Brown, despite the bad grade her hospital received. "We have focused ourselves on transparency."

Veal said Swedish hasn't taken the step of posting its internal infection-rate statistics yet, but it might be a good idea. The widespread posting of that data within the hospital system had a good effect, he said. He said the hospital began three years ago posting infection rates for every unit in the hospital on its intranet, "so everyone (working at the hospital) could see it." As a doctor with access to that information, he benefitted when his mother checked into Swedish a year ago for a major surgery. "You can bet I checked who had what complication rates, what infection rates," he said. He acknowledged that the public probably ought to have the same access. "Just like we welcome transparency in government, we feel that it is appropriate for us to be transparent ourselves in our healthcare system," he said.

Transparency puts pressure on the staff, he said. "If you are going to be naked, you'd better be buff," he said. Among other things, Swedish has a intensive care unit quality-improvement committee that meets three Tuesdays each month to pore over the infection data, he said.

There could be flaws in the state's data, as is often the case with healthcare incident reporting.

Sharon Jenkins, quality manager for Mary Bridge, said variations in the way ventilator cases are tracked at her institution versus Children's Hospital and Regional Medical Center in Seattle could have impacted the score. She said, at the same time, her childcare hospital in Tacoma recognized a problem in mid-summer 2009 and has been focusing on ventilator treatment. "We've had several months now where we've had no VAPS (ventilator-associated pneumonias)," she said.

Some institutions saw the state's report as a snapshot, an anomaly, that might misrepresent their long-term performance. That was the gist of a prepared statement by Monte Bostwick, CEO of Yakima Regional Medical Center, in reaction to its low score for ventilator pneumonias. "Yakima Regional is committed to quality patient care and maintains strict adherence to evidence-based standards and practices to prevent VAP. We have critical care specialist physicians caring for every patient on a ventilator in our Intensive Care Unit. For the past three years, prior to 2009, our percentage of VAP rates has been below national average. In 2009, the only cases we had are those reported to the DOH in the first 6 months of the year. We did not have any other cases. While we strictly follow best practices, and regret even one patient acquiring VAP, we understand that outcomes can be affected by circumstances outside our control, including an individual patient's health condition."

The state's Web site includes footnotes from each hospital that received a bad score. Here are some of them:

"Harrison Medical Center has been implementing prevention since 2006. The four unrelated infections during this six month 2009 reporting period are consistent with a downward trend over the past three years."

"Highline Medical Center's rate is due to two unrelated cases in March (2009)."

"Providence St. Mary Medical Center's (Walla Walla) rate appears high due to just one infection in a small number of ventilator days."

"St. Clare Hospital's rate is due to two unrelated cases one in January and a second in February. The hospital reports having a program of prevention measures in place."

But Zbrorowski of the hospital association emphasized that when it comes to hospital-acquired infections, there is only one number worth achieving. "The gold standard is zero," she said.