

Patient Safety at Kaiser Permanente Westside Medical Center

Kaiser Permanente Westside Medical Center is committed to remaining a national leader in patient safety and becoming the safest place to give and receive care.

Patient safety requires providing patient-centered care that is reliable, effective, consistent, and safe. It is an ongoing and relentless commitment to build safer systems, using performance improvement methodology thereby preventing the preventable.

We aim to achieve this by monitoring our performance on certain patient safety measures which include:

- Catheter Associated Urinary Tract Infections (CAUTI)
- Central Line Associated Blood Stream Infections (CLABSI)
- Clostridioides Difficile Infections (CDI)
- Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia Infections
- Patient Falls
- Hospital Acquired Pressure Injuries (HAPI)

This document contains information related to these patient safety measures.

PREVENTING CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTI)

What are we measuring?

A urinary catheter is a thin tube placed in the bladder to drain urine. Urine drains through the tube into a bag to collect the urine. Patients with urinary catheters have a much higher chance of getting a urinary tract infection than patients who do not have a catheter. A urinary tract infection is an infection in the urinary system, which includes the bladder (stores the urine) and the kidneys (filter the blood to make urine). Germs (for example, bacteria or yeasts) do not normally live in these areas. If germs are introduced, an infection can occur. If patients have a urinary catheter, germs can travel along the catheter and cause an infection in the bladder or kidney, in which case it is called a catheter-associated urinary tract infection (CAUTI).

What are we doing to improve?

Efforts are being taken to prevent CAUTIs. Here are the highlights:

- Urinary catheters are only used when medically necessary. Alternatives to catheters are used whenever possible
- Urinary catheters are removed when it is no longer appropriate for the patient. Nurses regularly assess, document, and communicate the plan for catheter
- Securement device to keep the tube in place
- Urine collection bag kept below the level of the bladder
- Healthcare workers receive electronic reminders to assess if a catheter is still medically necessary for each patient
- Only properly trained nurses and healthcare personnel insert and maintain catheters
- Healthcare workers use an aseptic technique when the catheter is placed
- Healthcare workers clean their hands and wear gloves before and after touching the catheter
- Patients and families are educated on best practices to reduce CAUTI

How are we performing?

The Centers for Medicare and Medicaid Services (CMS) reports CAUTI using a standardized infection ratio (SIR), which compares the total number of infections to the predicted number of infections during a selected time period. The measure takes into account risk factors that may impact the number of infections at a facility, including facility size, the types of patients treated, and kinds of procedures performed. SIRs below 1 indicate that the observed number of infections during the measured period was lower than would be expected, while values above 1 indicate that the observed number of infections was higher than expected.

CMS Annual Data (Last updated 4/16/2023)

Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards	0.429
↓ Lower numbers are better	No different than national benchmark
	National benchmark: 1.000

For more information on this data, visit: (1) <https://www.medicare.gov/care-compare/> and search for the Kaiser Westside Medical Center, 2875 NW Stucki Ave, Hillsboro, OR 97124. Click on Complications and Deaths (2) <https://data.cms.gov/provider-data/dataset/4j6d-yzce>

PREVENTING CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSI)

What are we measuring?

A “central line” is a tube placed into a patient’s large vein, usually in the neck, chest, arm, or groin. The central line is often used to draw blood or give fluids or medications. It may be left in place for several weeks. A bloodstream infection can occur when bacteria or other germs travel into a “central line” and enter the bloodstream. Patients who develop a CLABSI may become ill with fevers and chills, or the skin around the central line may become sore and red.

What are we doing to improve?

Efforts are being taken to prevent CLABSIs. We follow best practice techniques outlined by the Centers for Disease Control and Prevention (CDC), which include:

- Proper hand hygiene
- Cleansing of the patient’s skin before line placement
- Use full barrier precautions during insertion
- Early line removal
- In addition, we bathe patients in the ICU with chlorhexidine daily and use special chlorhexidine sponge dressings on all central lines to reduce the risk of infection

How are we performing?

The Centers for Medicare and Medicaid Services (CMS) reports CLABSI using a standardized infection ratio (SIR), which compares the total number of infections to the predicted number of infections during a selected time period. The measure takes into account risk factors that may impact the number of infections at a facility, including facility size, the types of patients treated, and kinds of procedures performed. SIRs below 1 indicate that the observed number of infections during the measured period was lower than would be expected, while values above 1 indicate that the observed number of infections was higher than expected.

CMS Annual Data (Last updated 4/26/2023)

Central line-associated bloodstream infections (CLABSI) in ICUs and select wards ↓ Lower numbers are better	0.000 No different than national benchmark National benchmark: 1.000
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For more information on this data, visit: (1) <https://www.medicare.gov/care-compare/> and search for the Kaiser Westside Medical Center, 2875 NW Stucki Ave, Hillsboro, OR 97124. Click on Complications and Deaths (2) <https://data.cms.gov/provider-data/dataset/4j6d-yzce>

PREVENTING CLOSTRIDIODES DIFFICILE INFECTIONS (CDI)

What are we measuring?

Clostridiodes difficile (CDI), also known as “C. diff,” is a bacterium which can cause diarrhea and inflammation of the colon (large intestine). CDI usually occurs in patients who are taking or have recently taken antibiotics. The most common symptoms of CDI include watery diarrhea, fever, loss of appetite, nausea, and stomach pain. CDI can live as spores outside the human body for a very long time and can be found on objects such as bed linens, bathroom fixtures, and medical equipment. It can also be spread more directly through contaminated shared equipment and the hands of healthcare providers.

What are we doing to improve?

Efforts are being taken to prevent the spread of CDI. Here are the highlights:

- Patients with C-diff are placed in private rooms
- Healthcare providers wear gowns and gloves while providing care to patients with C-diff
- Employees wash their hands with soap and water after providing care to a patient with C-diff
- Proper cleaning of the environment and medical equipment is always done
- Appropriate testing method to identify C-diff infections is used
- Proper use of antibiotics is monitored

How are we performing?

The Centers for Medicare and Medicaid Services (CMS) reports CDI using a standardized infection ratio (SIR), which compares the total number of infections to the predicted number of infections during a selected time period. The measure takes into account risk factors that may impact the number of infections at a facility, including facility size, the types of patients treated, and kinds of procedures performed. SIRs below 1 indicate that the observed number of infections during the measured period was lower than would be expected, while values above 1 indicate that the observed number of infections was higher than expected.

CMS Annual Data (Last updated 4/26/2023)

Clostridium difficile (C.diff.) intestinal infections ↓ Lower numbers are better	0.832 No different than national benchmark National benchmark: 1.000
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For more information on this data, visit: (1) <https://www.medicare.gov/care-compare/> and search for the Kaiser Westside Medical Center, 2875 NW Stucki Ave, Hillsboro, OR 97124. Click on Complications and Deaths (2) <https://data.cms.gov/provider-data/dataset/4j6d-yzce>

PREVENTING METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) BACTEREMIA

What are we measuring?

Staphylococcus aureus is a very common bacterium found on the skin or in the nose of about 1 out of every 3 people. Usually, this bacterium does not cause problems, but under the right circumstances it can cause serious infections such as skin or wound infections, pneumonia, or infections of the blood (bacteremia). Methicillin-resistant staphylococcus aureus (MRSA) is a type of Staphylococcus aureus that is resistant to some of the antibiotics often used to treat these infections.

What are we doing to improve?

Efforts are being taken to prevent the spread of MRSA.

Here are the highlights:

- Use of appropriate personal protective equipment
- Patients placed in a private room to prevent cross contamination
- Active surveillance screening for MRSA for selected procedures-decolonization protocol
- Standard precautions, for history of or well-contained infections
- Contact precautions for major wound infection/uncontained source
- Proper cleaning of the environment and equipment is always done

How are we performing?

The Centers for Medicare and Medicaid Services (CMS) reports MRSA using a standardized infection ratio (SIR), which compares the total number of infections to the predicted number of infections during a selected time period. The measure takes into account risk factors that may impact the number of infections at a facility, including facility size, the types of patients treated, and kinds of procedures performed. SIRs below 1 indicate that the observed number of infections during the measured period was lower than would be expected, while values above 1 indicate that the observed number of infections was higher than expected.

CMS Annual Data (last updated 4/26/2023)

Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections	1.587
↓ Lower numbers are better	No different than national benchmark
	National benchmark: 1.000

For more information on this data, visit: (1) <https://www.medicare.gov/care-compare/> and search for the Kaiser Westside Medical Center, 2875 NW Stucki Ave, Hillsboro, OR 97124. Click on Complications and Deaths (2) <https://data.cms.gov/provider-data/dataset/4j6d-yzce>

PREVENTING PATIENT FALLS IN THE HOSPITAL

What are we monitoring?

Falls can occur in any setting. In the hospital, the risk of falling may be greater due to a different environment and a change in routine from what patients are accustomed to. Medicines, illness, surgery and treatments could make patients feel dizzy and mildly confused. These factors could affect a patient's ability to safely get up and out of bed.

What are we doing to improve?

Efforts are being taken to prevent patient falls. Here are the highlights:

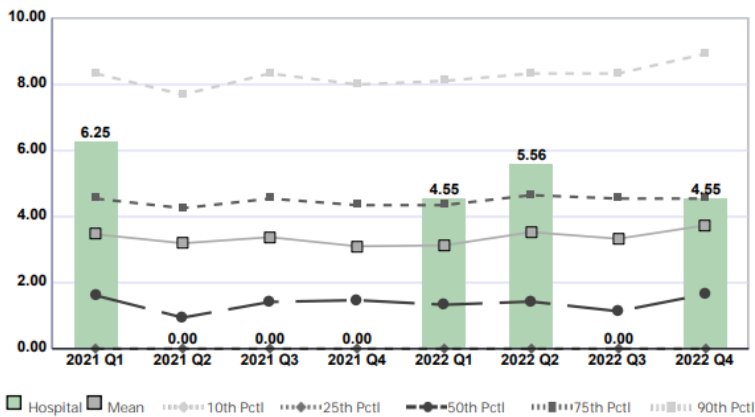
- Nurses follow universal fall prevention strategies to create a safe environment that reduces accidental falls for all patients
- Mobility support equipment is available to help ensure the safe transfer of patients at risk of falling
- Non-skid socks are offered
- Walking may be offered to prevent weakness and assistance is offered when using the restroom
- Use visual cues to alert others of fall risk

How are we performing?

In most cases, falls do not result in injury. According to the National Data for Nursing Quality Indicators (NDNQI), a fall in the hospital is defined as an unplanned descent to the ground. The hospital submits data on a quarterly basis to NDNQI, which is a national database that measures nursing quality and enables hospitals to compare progress with other hospitals nationwide. The data submitted includes Falls per 1000 patient days and Falls with Injury per 1000 patient days. Lower numbers are good.

Percent of Patient Falls that were of Moderate or Greater Injury Severity

(Most recent available data: 4Q 2022)



PREVENTING HOSPITAL ACQUIRED PRESSURE INJURIES (HAPI)

What are we monitoring?

A pressure injury is localized damaged to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. A hospital acquired pressure injury (HAPI) is an injury that develops 24-hours or more after hospital admission.

What are we doing to improve?

Efforts are being taken to prevent HAPIs. Here are the highlights:

- Patient assessments to determine risk of developing a HAPI with customized interventions incorporated into patient care plans as needed
- Interventions may include routine skin inspection, specialty surfaces, frequent turning and repositioning, addressing moisture, eliminating friction and shear, mobility and providing nutritional support

How are we performing?

Data is submitted on a quarterly basis to the National Data for Nursing Quality Indicators (NDNQI). NDNQI is a national database that measures nursing quality and enables comparison with other hospitals nationwide. The data includes the total number of patients with a pressure injury in a hospital unit on the day of the pressure injury survey. Lower numbers are good.

Percent of Surveyed Patients with HAPI Stage 2 and Above
(Most recent available data: 4Q 2022)

