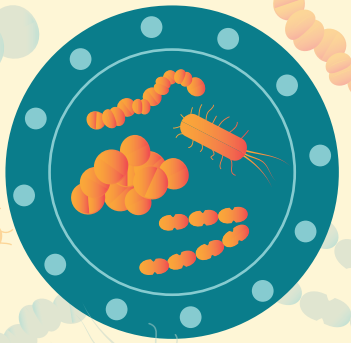
Washington State Healthcare-Associated Infection (HAI) External Validation of Acute Care Hospital HAI Data:

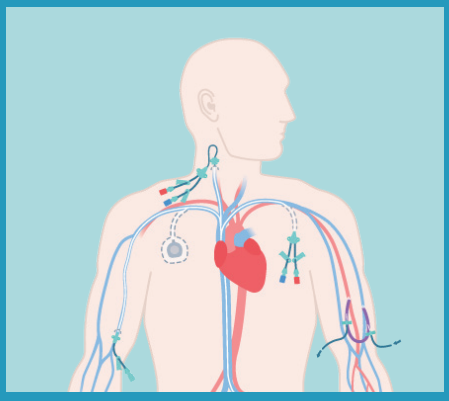


Central Line-Associated Bloodstream Infection (CLABSI)

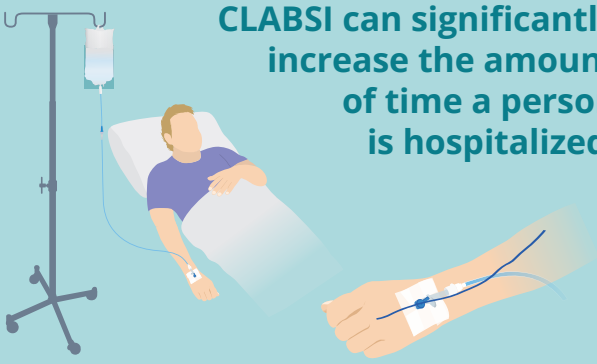
According to the Centers for Medicare & Medicaid Services (CMS) and the Washington State Healthcare-Associated Infection (HAI) Reporting Statute, acute care hospitals must report certain healthcare- associated infections to the Centers for Disease Control's (CDC) National Healthcare Safety Network (NHSN). This data reporting improves patient safety. The Washington State Department of Health (DOH) Healthcare- Associated Infections (HAI) Epidemiology team reviews the data and can assist hospitals in reporting.

2022 HAI Validation: CLABSI

A central line (also known as a central venous catheter) is a catheter (tube) that doctors often place in a large vein in the neck, chest, or groin to give medication or fluids or to collect blood for medical tests. A central line-associated bloodstream infection (CLABSI) is a serious infection that occurs when germs (usually bacteria) enter the bloodstream through the central line.



In the US, CLABSI increases mortality by 12-25%, and is associated with over 28,000 deaths yearly.



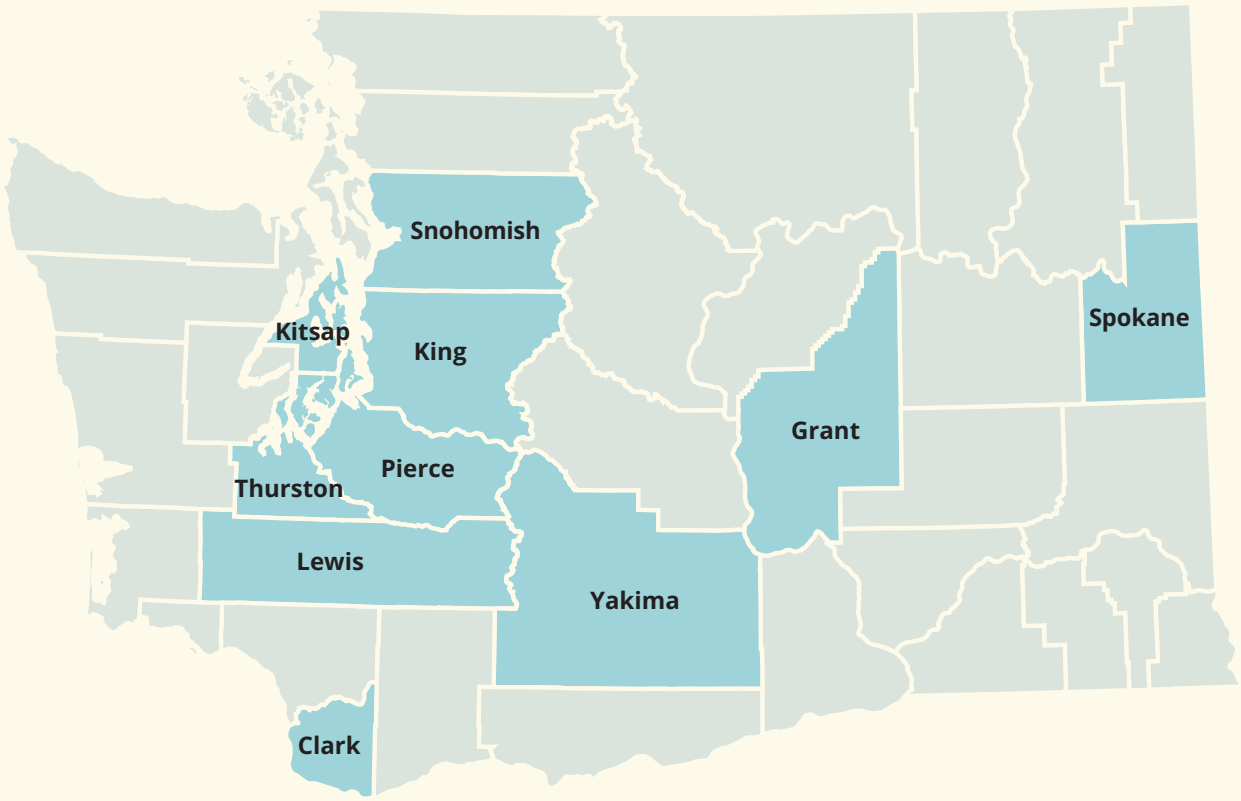
CLABSI can significantly increase the amount of time a person is hospitalized.

Methodology

The HAI Epidemiology team performed validation of 2022 CLABSI data that was reported to NHSN. There were 22 acute care hospitals in 10 counties that participated in the CLABSI event validation. The team selected hospitals according to the 2022 NHSN Toolkit and Guidance for External Validation. The process included reviewing up to 40 positive blood cultures for each hospital using a standardized tool. The team determined whether the events met reporting criteria and compared the determination with what the hospital reported to NHSN.

Validations by County

Washington counties where external CLABSI validations were conducted



The DOH epidemiologist(s) and the hospital Infection Prevention team settled any discrepancies. A discrepancy was defined as a situation where the DOH epidemiologists' and the hospital Infection Preventionists' reporting determinations were different.

Results

In total, 883 cases were reviewed across the 22 hospitals. Of the hospitals validated, 12 (54%) had no discrepancies. Of those facilities with discrepancies, most had fewer than 10% discrepancies; there were 20 (0.02%) total discrepancies.

10
Counties

22
Hospitals

883
Cases Reviewed

8
Remote Visits

14
Onsite Visits

98%
State-wide Reporting Accuracy

95%
of CLABSIs were correctly identified

98%
of non-CLABSIs were correctly identified

Please contact HAI@doh.wa.gov with any questions.

Washington State Department of HEALTH

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