WORK-GROUP MEETING – MINUTES
Surveillance of bloodstream infections in Belgian hospitals (BSI) – Surveillance of Clostridium difficile infections (CDI) – Quality indicator project in Belgian hospitals

Date	November 19, 2018 13:00– 17:00
Venue	Auditorium Storck – Scienscano-Eurostation
Attendees	Metango Albertine (CHU Brugmann), Foulon Anne-Marie (CH Mouscron), Scohy Anaïs (UCLouvain), Vanrenterghem Dirk (Jan Yperman Ziekenhuis), Antoine Françoise (CHU St Pierre), Van Esch Gretel (Silva Medical), Manderyck Greet (AZ St. Lucas Brugge), Bruyneel Heidi (AZ Groeninge), Wybo Ingrid (UZ Brussel), Boelens Jerina (UZ Gent), Demunck Jo (AZ St. Blasius), Vanbroeck Johan (CNR UCLouvain), Maelegheer Karel (AZ St. Lucas Gent), Floré Katelijne (AZ St. Jan), Rottiers Kim (OLVZ Aalst), Vereycken Marylene (Clinique St. Jean), Van den Driessche Natalie (AZ Jan Portaels), Gadisseux Philippe (CH Mouscron), Demeest Rémy (CHU Charleroi), Mokrane Saphia (Hôpitaux IRIS Sud-IZZ), Saegeman Veroniek (UZ Leuven), Delestrait Michèle (HUDERF), De Keyser Saskia (AZ Oudenaarde), Laurent Christine (CHR Namur), De Vlaminck Annick (Algemeen Stedelijk Ziekenhuis), Dispas Céline (CHR Citadelle), Mascart Georges (CHU Brugmann), Mahadeb Bhavna (LHUB-ULB), Verblaeken Nicole (UZ Brussel), Denis Olivier (CHIREC), De Loecker Robert (Sint-Maria), Monsieur Annick (Sint-Maria), Hoxha Ana (Sciensano), De Pauw Hélène (Sciensano), Vandael Eline (Sciensano), Tsou Latsap Carine (Sciensano), Miller Elisabeth (Sciensano) **Sciensano - Healthcare-associated infections & antimicrobial resistance:** Catry Boudewijn, Duysburgh Els, Mortgat Laure, Dequeker Sara Kris Vrancken, Phidias Dzaomuho - Lenieregue (only for presentation on Healthdata)
Apologies	Marot Anne-Marie (CH Haute Senne), Tilmanne Anne (HUDERF), Léon Véronique (HUDERF), Bart Gords (zna), Hilde Jansens (uUZA), Kristien Van Vaerenbergh (olvz-Aalst), Lydwine Defourny (chu-Charleroi) Sophie Browet (Clinique St-Pierre)

1. Surveillance of bloodstream infections (BSI) in Belgian hospitals

Presentations:
The presentations of this meeting can be found in X:\S-SPECIFIC\COMMON SEP CDIF QI\Working Group\Working 2018\Presentations and on the NSIH website.

Objectives of the meeting:
- To present main results of annual report 2018
- To discuss results and protocol

Decisions made:

TOPIC	DECISION MADE AND ACTIONS
Remove from the BSI surveillance collection of data on **antibiotic resistance profiles** collected for selected microorganism	Antibiotic resistance data as they are asked at present in the BSI surveillance are not useful and relevant for the Belgian context and should be streamlined with the recommendation on resistance testing given by the Superior Health Council (Hoge Gezondheidsraad/Conseil Supérieur de la Santé). As resistance data are also asked in other surveillances (e.g. EARS-net, MDRO surveillance) these should not be asked again as part of the BSI surveillance.

	To do: Address the streamline of antibiotic resistance data collection within Sciensano so that this part can be removed from the BSI-surveillance (ED).
Registration per **campus** or per **hospital group**	It was agreed that, as in the past, it is the hospital that decides at which level they report; at campus or hospital group level. But this reporting level should be consistent for all the NSIH-coordinated surveillances and the denominator registration. **To do**: Add variable at participation page in Healthdata where the data provider has to indicate if they register at hospital or campus level (Healthdata and ED)
Registration of **denominator** data in Healthdata	Since the migration to Healthdata we notice that more hospitals than before did not register denominator data (for the whole hospital and for the intensive care units). This has to be done through a separate register in Healthdata. **To do:** Register denominator data in separate Healthdata register (data providers)
'Ward speciality' versus **'patient speciality'**	It was decided not to change the protocol regarding this and continue asking only the 'ward speciality'.
Reporting of **healthcare associated BSI outside hospital** setting	It was decided not to add this to the protocol yet but to keep this in mind.
Terminology: use **'blood culture'** (=hemocultuur) (ECDC) or **'blood specimen'** (=bloedstaal) (CDC)	It was decided not to change the terminology in our surveillance and keep using 'Blood culture'.
Individual online feedback and reporting of BSI at **hospital level** in Healthstat	If individual BSI reports become available at Healthstat data providers are requested sending us their comments and inputs on these reports.
Publication of BSI report 2018	It was decided that 1 week before the publication of the report at our website the report will be send for information to all participating hospitals. **To do:** Send BSI report 1 week before the publication to all participating hospitals.
GENERAL	
	Annual report will be published (online) in December 2018. The report will be in English with elaborated executive summary in French and Dutch

2. Healthdata

Presentations:
The presentations of this meeting can be found in X:\S-SPECIFIC\COMMON_SEP_CDIF_QI\Working_Group\Working 2018\Presentations and on the NSIH website.

Objectives of the meeting:
- Give an overview of data collection issues and the roadmap to resolve these issues
- Give an overview of the reporting via Healthstat

Decisions made:

TOPIC	DECISION MADE AND ACTIONS
Data-extraction from local HD4DP	If the data provider extract data from HD4DP, he/she receive coded data. Is it possible to make this more user friendly? Is it possible to decode these data automatically instead of manually? This has been promised by the start of Healthdata, but has not been realised yet.

	To do: Ask Johan van Bussel (Coordinator Healthdata.be) to provide in HD4DP extractions with labels in stead of codes and follow up this request (ED).
CSV upload	Using CSV uploads takes a lot of time and gives a lot of validations errors. Phidias (support Healthdata) will organise hands on session, to explain how to use CSV to the data providers. There has been chosen for hands on and practical session instead of an theoretical explanation at the regional platforms for hospital hygiene. **To do:** organizing hands on session about how to use CSV files (PDL)

3. Surveillance of *Clostridium difficile* infections (CDI) in Belgian hospitals

Presentations:
The presentations of this meeting can be found in X:\S-SPECIFIC\COMMON_SEP_CDIF_QI\Working Group\Working 2018\Presentations and on the NSIH website.

Objectives of the meeting:
- To present results annual report 2018
- To discuss results and protocol

Decisions made:

TOPIC	DESCRIPTION AND ACTIONS
Preliminary results 2017 : presentation and discussion	Main point of discussion was the **discrepancy between surveillance data and RHM/MZG data :** surveillance underestimates the incidence by 20%+-, WHY? Surveillance incidence uses cases (numerators) and denominators provided by the hospitals themselves, RHM/MZG uses comprehensive recording of ICD 9-ICD10 codes for "enterocolitis due to CDI" and comprehensive denominators provided by hospitals too. How is data entered? How is the infection defined by people entering the data? **To do: Validation study** of both our surveillance data and RHM data (LM and ED)
Discussion: CDIF protocol update **1. Objectives**	1. Proposal to add to the objectives at the "national level": - "***make the link with environmental strains***" **To do: No**, it is not the purpose of the surveillance, rather the subject of research - "***Be equipped to monitor antimicrobial susceptibility if necessary***". **To do: Ok** even if not really needed today 2. Proposal to add an "**international level**" to the objectives: - " *Describe the impact of CDIs at European and international level*" - "*Check the impact of any prevention plans*" - "*Identify risks or detect threats*" - "*Prepare for potential or proven risks*" **To do**: update protocol accordingly. Ok for the first two sentences, the last 2 sentences combined in "*identify potential risks and be prepared to face them if necessary*" (LM)
Discussion: CDIF protocol update **2. Participation**	Discussion of the **possibility to register** "per site", "per entity" or **"for one or more combined sites"**, with a proposal to delete the last option. Initially accepted, then possibility emerged that this sentence is relevant for hospitals that include acute and chronic sites. **To do:** **-** Specify that this option **is only valid in case one of the sites is a chronic site**.

	- In HD, **specify on the participation page** if participation is by group/site/sites, but must be kept the same for the whole year, for all the surveillances, and for the denominators! LM and HD)
Discussion: CDIF protocol update **3. Inclusion criteria**	Proposal to **delete the possibility of encoding CDI cases for "*patients in day hospitalisation or ambulant patients (e. g. dialysis patients)*"** in the numerators. Indeed, these patients are not included in the denominators and thus the incidences, but not easy to extract them from the database for analysis. Proposal to add in this case a variable "hospitalized patient VS ambulant"? **To do**: No, it is easier to **remove this possibility from the protocol**, as ECDC does. (LM)
Discussion: CDIF protocol update **4. Microbiological aspects**	1. Suggestion to add to "*participation in the CDI surveillance necessarily implies **culture**...*" the following sentence: "*In the event that the participating laboratory no longer carries out culture or encounters difficulties in carrying it out, **the NRC may isolate the strain directly from the stool sample** which must therefore be sent to it*". For the moment, this concerns 10% of the samples sent (NRC). Fear that, on one hand some hospitals are only performing culture in this context and may therefore lose their "know-how"/technical skills in this field (better then to do it in the NRC), and on the other hand that by adding this option, many hospitals will stop doing culture and send their stool samples directly, which would generate an additional cost for the NRC, cost that is not currently budgeted. **To do: Mail to send to the data providers to know who still performs culture suggested (?)** 2. Proposal to remain on a semi-annual surveillance, and send to the NRC the "first 5 consecutive strains maximum per hospital per surveillance period". Subject quickly touched on, not investigated in depth due to lack of time. **To do:** for the moment **keep things that way.** 3. What about testing for **antimicrobial susceptibility** (metronidazole; vancomycin, moxifloxacin) recommended by the ECDC for the first 5 consecutive strains? In Belgium, this does not seem necessary at the moment. However, “constant and high vigilance and preparedness » in this regard is required. **To do: No antimicrobial susceptibility testing for the moment**, discussion to be planned for possible future sampling on this subject
Discussion: CDIF protocol update **5.New variables to add in HD4DP**	**1. “Reason typing requested”:** variable recommended by ECDC. Given the large number of strains sent to the NRC (>5/sem/hop), il would be useful to know the reason for the shipment. Optional variable, with following choices : “surveillance”/ « outbreak investigation »/ « severe case »/ « unknown ». Suggestion to to put it in a "pop-up" window when the answer to the variable « Strain transferred to Reference Laboratory UCL" is « yes". **To do: OK** (LM and HD) **2. “Previous healthcare admission”:** variable recommended by ECDC. Allows to know if there was a contact with a healthcare institution (LTCF, other hospital, other institution, combination of various institutions) in the 3 months preceeding the CDI. Optional variable, with following choices: yes / no / unknown. Redundancy with variable "Origin of the presumed case”? **To do:** Topic quickly touched on, not investigated in depth due to lack of time, **to be discussed at the next** revision of the 2020 Protocol
GENERAL	
Discussion: Healthdata collection and reporting	**1. Healthstat:** reporting of 2017 data scheduled week of the 27/11 **2. Data validation and individual feedback update scheduled every quarter**

	3. Discussion about the possibility to have a **« real time » feedback on HD4DP** for data entered at hospital level but not yet validated by the researchers : **To do:**, this is **not felt as necessary** for the providers, quarterly validation and update enough

4. Quality Indicator Project

Presentations:
The presentations of this meeting can be found in X:\S-SPECIFIC\COMMON SEP CDIF QI\Working Group\Working 2018\Presentations and on the NSIH website.

Objectives of the meeting:
- To present the new configuration of the report
- To align the report with the wishes/needs of the hospitals

Decisions made:

TOPIC	DECISION MADE AND ACTIONS
Individualized quality report per hospital in Healthstat	Adding the national percentage of hospitals with a '1'-score to the individual report for each hospital is wanted. **To do**: add this national percentage to the individual reports (Healthdata and SD)
Quality classes (Good, moderate and bad quality)	Quality classes are present for each indicatorgroup. In the previous report these were presented by a bar graph. This is easy to understand. A boxplot can give more information. Both will be presented in the next report. **To do:** add a boxplot to the report (SD)
Publication of the report	The QI report is used to show the management of the hospital where they stand and what they still need to achieve. The report will be published with a press release. The hospitals preferred to receive the report one week in advance, so they don't have to learn the results from the media. **To do:** Sent the reports of SEP, CDIF and QI one week in advance to the dataproviders (ED, LM, SD).
GENERAL	
	Annual report will be published (online) as soon as possible. The report will be in French and Dutch.