
Summary of the Review of Public Comment Feedback on the Draft HISO 10058.1 Infection Surveillance Data Standard

Citation: Ministry of Health. 2021. *Summary of the Review of Public Comment Feedback on the Draft HISO 10058.1 Infection Surveillance Data Standard*.
Wellington: Ministry of Health.

Published in April 2021 by the Ministry of Health
PO Box 5013, Wellington 6140, New Zealand

ISBN 978-1-99-100706-3 (online)
HP 7656



This document is available at health.govt.nz



This work is licensed under the Creative Commons Attribution 4.0 International licence. In essence, you are free to: share ie, copy and redistribute the material in any medium or format; adapt ie, remix, transform and build upon the material. You must give appropriate credit, provide a link to the licence and indicate if changes were made.

Contents

Background	1
1 Source of responses and number of responses received	2
2 Summary of responses and outcomes	3
3 Future considerations	6
List of Tables	
Table 1: Submissions received by organisation type	2
Table 2: Summary of feedback received from public consultation	3

Background

The draft HISO 10058.1 Infection Surveillance Data Standard (the standard) was developed by a working group, comprising subject matter experts, in consultation with stakeholders and users of existing infection surveillance systems. The standard defined the minimum information that needs to be captured for a patient's health care encounter when a suspected or confirmed infection has been identified. The standard covered infections identified in both community and hospital settings.

HISO approved the release of the draft HISO 10058.1 Infection Surveillance Data Standard (the standard) for public comment on 19 August 2020. The Ministry of Health (the Ministry) sought public comment on the standard from 2 October 2020 for a period of six weeks, closing 13 November 2020. The Ministry received 16 submissions.

The public comment feedback was reviewed by a working group consisting of clinical microbiologists, infectious diseases physicians, infection prevention and control specialists, business intelligence and analytics, and business systems analysts. The members included representatives who have experience with an infection surveillance system (either ICNET or an internally developed system) as well as representatives who use other mechanisms to obtain the infection information they require.

This document summarises responses received as a result of the public comment process and provides an overview of the decisions made by the working group. This document includes:

- the source of the responses and the number of responses received
- the summary of the responses and the outcome of the working group's review.

1 Source of responses and number of responses received

Table 1 lists the responses received from the public consultation by organisation type. In some instances, a group of individuals representing a single organisation submitted collated feedback.

Table 1: Submissions received by organisation type

Response type	Number of responses	Number of individual comments received
District health boards	3	21
Government agencies	2	4
Primary health care services	1	29
Private hospitals	4	18
Representative organisations/groups	4	42
Other	2	6
Total responses	16	120

2 Summary of responses and outcomes

Table 2 provides an overview of the feedback received from respondents in the public comment process and the outcomes agreed by the working group.

Note: Where feedback has been covered under 'General comments,' it has not been repeated in the specific sections.

Table 2: Summary of feedback received from public consultation

Brief overview of feedback	Outcome
<p>General comments:</p> <p>We received mixed feedback around the development of the draft Infection Surveillance Data Standard (the standard). The majority of respondents supported a nationally consistent approach to infection surveillance. The standard was considered easy to read, well presented and generally sound – a good base to start from.</p> <p>Some respondents felt that the context was not clear, nor was it clear which part of the health and disability sector the standard applied to.</p> <p>Auto population and sharing of information between systems would be necessary to ensure the standard is implemented successfully.</p> <p>Private hospital respondents advised that, in the current situation, they could not capture and submit a significant amount of data on the experiences of patients who have elective surgeries in the private setting.</p>	<p>The working group acknowledged the support from those who provided feedback.</p> <p>They agreed that the context was not clear and changed the scope of the standard to initially reflect just health care associated infections in publicly funded hospitals. However, they also asked that the standard include a recommendation for the private sector and other health organisations to use it when implementing an infection surveillance system.</p> <p>Further revisions of the standard would broaden its scope.</p> <p>The working group updated the standard to support the Ministry's vision to accelerate the shift to a fully interoperable digital health ecosystem.</p> <p>References to electronic sharing and auto population of information were strengthened.</p>

Brief overview of feedback	Outcome
Are the minimum data elements identified in the standard sufficient?	
<p>Respondents felt that occupation and employer details should be included as optional fields for monitoring to support reducing infection incidence and further outbreaks.</p>	<p>The working group decided that data elements for occupation and employer should be considered in a future version of the standard.</p>
<p>They also felt some fields needed to be altered to provide a reliable way for patient follow-up, and additional information around managed isolation facilities needed to be included.</p>	<p>The working group disagreed with the idea of including information relating to the care of the patient as this standard is for surveillance of infections not management of the patient's infection – with this type of information captured in the clinical record. References to managed isolation facilities have been included in the standard where applicable.</p>
1 Introduction	
<p>Respondents felt it is not clear whether the intent is to provide minimum standards for surveillance of all 'infections' or a subset of infections, such as 'infections due to specific organisms'.</p>	<p>The working group agreed to adjust the introduction to more specifically reflect that the intent of the standard was for surveillance of all health-care-associated infections.</p>
<p>They felt the standard needs to include reference to the Health and Safety at Work Act 2015, section 199, which requires Worksafe New Zealand to be notified about work-related infections. Respondents also proposed other minor changes to the introduction.</p>	<p>The working group felt that a Worksafe New Zealand notification as suggested by the respondents would not come from the surveillance system but from a patient's clinical record. The scope and purpose were updated to reflect recommended changes.</p>
2 Patient	
<p>Respondents requested the following details be included:</p>	
<ul style="list-style-type: none"> • gender 	<p>The working group advised that this was not required as the system would not be used when interacting with a patient. They advised that sex, with the values of male and female, is all that is required at this point and asked that this data element be revised once Stats NZ have published their consultation outcome.</p>
<ul style="list-style-type: none"> • procedure 	<p>The 'procedure' data element was added as an optional field, but the working group felt that further work would be needed to refine 'procedure'. This will be put forward in a future review.</p>
<ul style="list-style-type: none"> • comorbidities 	<p>The working group felt that 'comorbidities' should be left for future development to ensure what is captured is fit for purpose.</p>

Brief overview of feedback	Outcome
<p>3 Encounter</p> <p>Some respondents were concerned that using SNOMED CT may be a danger to both data integrity and patient management as a code may not exist for novel diseases.</p> <p>They asked that a mandatory field for clinical diagnosis of infection be added.</p> <p>Respondents also made other minor requests.</p>	<p>The working group are satisfied with the use of SNOMED CT. They were impressed with the number of available novel diseases in SNOMED CT and the quick turnaround to create new terms for new infections.</p> <p>The working group asked that the suggestion of a mandatory field for clinical diagnosis be put on the list of things to consider in a future review as it depends on the development of an agreed national criteria for infections (outside the scope of this standard).</p> <p>Other data elements that were requested that will be considered in a future review include 'Infection onset date' and 'Source of infection'.</p>
<p>4 Observation</p> <p>Respondents felt that recording non-laboratory data would happen multiple times during an encounter and it is not clear which ones would be expected to be recorded.</p> <p>They see 'Multidrug-resistant organism' as a valuable data point but felt more detail is required so that national resistance patterns can be easily monitored.</p> <p>Respondents also made other minor requests.</p>	<p>The working group felt that some of the non-laboratory data can be retrieved through the clinical records, and therefore, they have removed most of the data elements from the standard.</p> <p>The working group agreed that 'Multidrug-resistant organism' is a valuable data point, however, they felt that, as this data point is more complex and requires time to consider the relevant fields, it should be included in a future review.</p> <p>'Antibiotic' was changed to 'antimicrobial'. The working group agreed to remove the data elements for 'Organism growth' and added 'Specimen source', 'Route of administration' and 'Dose frequency'.</p>

3 Future considerations

The working group felt that, at this stage, the minimum and most appropriate information for infection surveillance is covered by this first iteration of the standard (relating to health care associated infections). They felt that the types of data to be collected, albeit useful, are more complex and need further investigation and recommend that future updates consider the inclusion of suggested data elements.