Taiwan Nosocomial Infections Surveillance System

I. Preface

The "nosocomial infection" is limited to describing infections that acquired in hospitals, while the "healthcare-associated infection" (HAI) generally refers to infections that patients acquire while receiving treatment for medical or surgical conditions. HAIs may occur in all settings of care, including hospitals, long-term care facilities, homecare facilities, or outpatient departments. In order to respond to continuous evolving in the contents of medical services and the expansion of surveillance range, "healthcare-associated infection" instead of "nosocomial infection" was commonly used internationally as well as in the definition of infection surveillance in the acute care settings that published by the US CDC in 2008. To monitor the occurrence of HAIs effectively, to evaluate the epidemiologic trend of HAIs in Taiwan, and to analyze surveillance data using well-recognized indicators, so that all the information could be made use of collectively to serve as important references for policy making, Taiwan CDC had revised and launched the Taiwan Nosocomial Infections Surveillance System (TNIS System) in 2007. Moreover, strengthening in functions and the utility of the surveillance system is continuously going on. TNIS system not only helps to gather demographic data as well as laboratory results of pathogen identified and antimicrobial susceptibility test for each HAI case, but also provides simple analytical function, so that reporting hospitals can analyze their own data online as a reference in developing quality improvement initiatives.

II. Objectives

1. Establish the epidemiological database of HAI in Taiwan
2. Discovery of HAI trends
3. Facilitation of inter- and intra-hospital comparisons that can be used for quality improvement activities
4. Assistance for hospitals in developing the appropriate surveillance mechanism that permits timely recognition of infection control problems

III. Reporting methods, data analysis, and feedback

TNIS system adopts voluntary reporting, and each hospital may provide their data either through web-based entry or convey their data electronically through interchange platform. The web-based report mechanism mainly serves for the hospitals which lack HAI surveillance system of their own. Hospital staff enters the HAI data on the TNIS system website directly. The other mechanism, conveying surveillance data

electronically through interchange platform, serves for the hospitals which had built their own HAI surveillance system. However, to enable interoperability between hospital information systems (HIS) and TNIS system, infection control practitioner has to work on vocabularies mapping from local to standard codes and hospital information technology staff has to bridge the connection between the two systems and make the electronic data pack in a standard format according to the working instruction issued by Taiwan CDC. Through this mechanism, surveillance data could be routinely transferred from hospital information systems to the TNIS system automatically. This can save the hospital staff a lot of time because they would not need to repeatedly enter the data to both of hospital surveillance system and TNIS system. At present, more than 500 hospitals enrolled in TNIS system. Hospitals may use TNIS system to manage HAI cases and generate individual hospital reports. Also, Taiwan CDC periodically feedback hospitals with national report as a reference for inter- and intra-hospital comparisons, hope to facilitate hospitals to improve their quality in controlling HAIs and to safeguard the wellbeing of healthcare workers and the general public.

IV. Healthcare-associated infection surveillance data analysis content

1. Number of medical centers and regional hospitals contributing ICU HAI data in this report in 2016.
2. Distribution of HAI rates by type of location in the ICUs of medical centers and regional hospitals in 2016.
3. Distribution of device-associated infection rates in the ICUs of medical centers and regional hospitals in 2016.
4. Distribution of major sites of HAI in ICU patients from medical centers and regional hospitals in 2016.
5. Common pathogens of HAI for patients in the ICUs of medical centers in 2016.
6. Common pathogens of HAI for patients in the ICUs of regional hospitals in 2016.
7. Antimicrobial resistance proportions of selected pathogens of HAI in the ICUs of medical centers and regional hospitals in 2016.

V. Surveillance method and main results

All the analytical results in this report were derived from TNIS system database with data updated to Aug 14, 2017. In 2016, there were 22 medical centers (195 ICU units) and 84 regional hospitals (268 ICU units) reported both HAI cases and the number of patient-days to TNIS system for at least one calendar month (Table 10). The distributions of HAI rate ((number of HAIs / number of patient-days) ×1000‰) in ICUs of medical centers and regional hospitals are shown in Table 11. There were 4,863 episodes of HAI events occurred during 812,961 patient-days in the ICUs of 22 medical

centers; the rate of infections was 6.0‰. However, in the ICUs of the 84 regional hospitals, there were 4,040 episodes of HAI events occurred during 868,796 patient-days; the rate of infections was 4.7‰. The HAI rates of ICUs were higher in medical centers than those in regional hospitals by corresponding types of ICU. The distributions of device-associated infection rate in ICUs ((number of device-associated infections / number of device-days) ×1000‰) are shown in Figure 2. The pooled mean of central line-associated bloodstream infection (CLABSI) rates was 4.2‰ in medical centers and 3.1‰ in regional hospitals, and the pooled mean of catheter-associated urinary tract infection (CAUTI) rates were 3.3‰ and 2.5‰ respectively, the rate of CAUTI and the rate of CLABSI in ICUs of medical centers are higher than those in regional hospitals; the pooled mean of ventilator-associated pneumonia (VAP) rates in regional hospitals is higher than that in medical centers, which are 1.1‰ and 0.6‰ respectively.

The distribution of site-specific HAIs in ICUs is shown in Table 12, with the bloodstream infections topped the list in medical centers (44.0%), followed by urinary tract (34.6%), and pneumonia (8.6%). In regional hospitals, the urinary tract infections topped the list (38.3%), followed by bloodstream infections (35.6%), and pneumonia (16.8%).The common pathogens for HAIs in ICUs are shown in Table 13 and Table 14. The top three pathogens in the ICUs were *Escherichia coli*, *Enterococcus faecium*, *Klebsiella pneumoniae* in medical centers and *Klebsiella pneumoniae*, *Escherichia coli*, *Candida albicans* in regional hospitals. The proportions of antimicrobial resistance among selected pathogens identified from patients in the ICUs with HAIs are shown in Figure 3. In the ICUs of medical centers, the proportion of *Acinetobacter baumannii* isolates those were resistant to carbapenem (CRAB) is 63.6%, the proportion of *K. pneumoniae* isolates those were resistant to carbapenem (CRKP) is 23.3%, the proportion of *Pseudomonas aeruginosa* isolates those were resistant to carbapenem (CRPA) is16.7%, the proportion of *Enterococci* isolates those were resistant to vancomycin (VRE) is 41.6%, and the proportion of *Staphylococcus aureus* isolates those were resistant to oxacillin (MRSA) is 66.8%. Meanwhile, the antimicrobial resistance proportions of selected pathogens isolated from patients acquired HAIs in the ICUs of regional hospitals were 73.8%, 27.3%, 15.2%, 36.2% and 68.1% for CRAB, CRKP, CRPA, VRE and MRSA, respectively.

VI. 2016 Data analysis of HAI in the ICUs of medical centers and regional hospitals

Table 10 Number of medical centers and regional hospitals contributing ICU HAI data in this report, 2016

Hospital level	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter	
	No. of hospitals	No. of HAIs	No. of hospitals	No. of HAIs	No. of hospitals	No. of HAIs	No. of hospitals	No. of HAIs
Medical center	22	1,309	22	1,188	22	1,147	22	1,222
Regional hospital	84	1,042	83	995	84	1,007	84	999

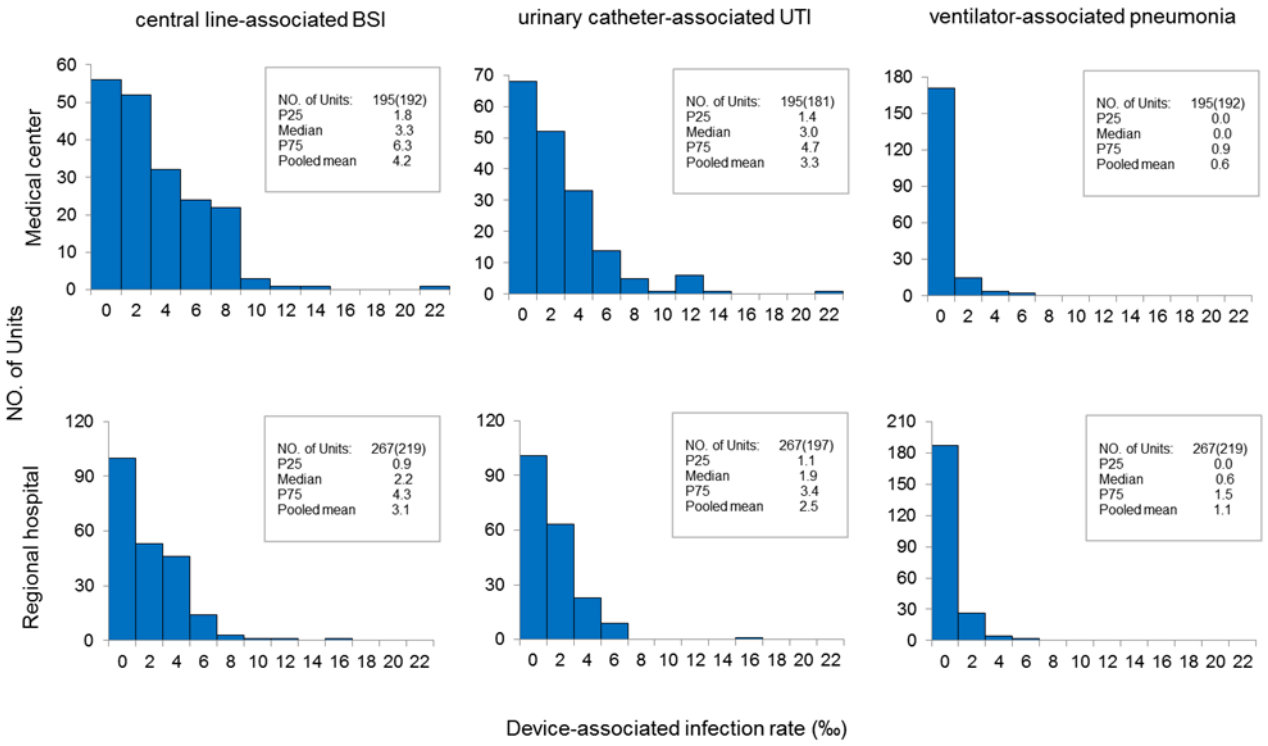
Note: Data updated to 2017/04/27

Table 11 Distribution of healthcare-associated infection rates by type of locations in the ICUs of medical centers and regional hospitals, 2016

Hospital level	Type of locations	No. of units[1]	No. of HAIs	Patient -days	HAI Rate[2] (‰)	Percentile		
						25th	50th	75th
Medical center	Medical ICU	55 (55)	1,738	249,132	7.0	4.9	6.3	8.8
	Surgical ICU	65 (65)	1,855	270,256	6.9	4.6	7.0	9.0
	Cardiology ICU	14 (14)	372	62,128	6.0	4.8	6.2	8.0
	Pediatric ICU	43 (43)	470	164,666	2.9	1.6	2.5	3.8
	Medical/surgical	18 (18)	428	66,779	6.4	3.4	5.2	9.5
	Total	195 (195)	4,863	812,961	6.0	3.4	5.5	8.2
Regional hospital	Medical ICU	58 (57)	1,054	257,075	4.1	2.7	3.7	5.4
	Surgical ICU	48 (46)	980	166,281	5.9	3.4	5.1	6.3
	Cardiology ICU	11 (10)	137	38,722	3.5	1.8	3.6	4.2
	Pediatric ICU	64 (57)	42	53,489	0.8	0.0	0.0	1.2
	Medical/surgical	87 (82)	1,827	353,229	5.2	3.3	4.3	6.7
	Total	268 (252)	4,040	868,796	4.6	1.5	3.7	5.9

Note: 1. Units with patient-days<50 are not included in percentile distribution; the number in parentheses is the number of units meeting minimum requirement for percentile distribution.

2. Healthcare-associated infection rate= (number of HAIs / number of patient-days) ×1000‰. For every unit, monthly data was included for analysis only when the patient days and number of HAI cases were both available.



Note: 1. device-associated infection rate= (number of HAIs / number of device-days) ×1000‰;

2. UTI, urinary tract infection; BSI, bloodstream infection;

3. Units with device-days<50 are not included in percentile distribution; the number in parentheses is the number of units meeting minimum requirement for percentile distribution.

Figure 2 Distribution of device-associated infection rates in the ICUs of medical centers and regional hospitals, 2016

Table12 Distribution of major types of healthcare-associated infection in the ICU patients from medical centers and regional hospitals, 2016

Types of infection	Medical center		Regional hospital	
	No.	%	No.	%
Urinary tract	1,683	34.6	1,549	38.3
Bloodstream	2,141	44.0	1,426	35.3
Pneumonia	419	8.6	680	16.8
Surgical site	262	5.4	164	4.1
Other	361	7.4	224	5.5
Total	4,866	100	4,043	100

Note: proportion of specific infection type= (number of specific infection type / number of overall infection)×100%

Table 13 Common pathogens of healthcare-associated infections in the ICUs of medical centers, 2016

Pathogens	Total		Types of Infection									
			Urinary tract		Bloodstream		Pneumonia		Surgical site		Others	
	Rank	No.	Rank	No.	Rank	No.	Rank	No.	Rank	No.	Rank	No.
Escherichia coli	1	552	1	355	7	133	8	10	2	35	8	19
Enterococcus faecium	2	438	4	165	2	222			7	24	6	27
Klebsiella pneumoniae	3	426	7	125	3	185	2	61	6	25	5	30
Candida albicans	4	419	3	253	8	130	16	2	8	21	11	13
Pseudomonas aeruginosa	5	411	5	143	10	112	1	68	1	53	3	35
Acinetobacter baumannii	6	397	9	62	1	246	3	51	9	16	7	22
Yeast-like	7	388	2	320	17	35	11	5	11	12	10	16
Other *Candida* spp. or NOS	8	318	6	127	4	170	21	1	11	12	14	8
Enterobacter species	9	264	10	49	6	145	6	23	4	30	9	17
E.cloacae		194		33		111		15		23		12
Other *Enterobacter* spp. or NOS		70		16		34		8		7		5
Enterococcus faecalis	10	244	12	18	5	146	4	33	10	14	4	33
Others		1,675		286		911		105		170		203
Total		5,532		1,903		2,435		359		412		423

Note: 1. isolates of the same species of bacteria, regardless of antimicrobial susceptibility pattern, are counted only once per patient per infection. That is, no duplicate isolates are included.

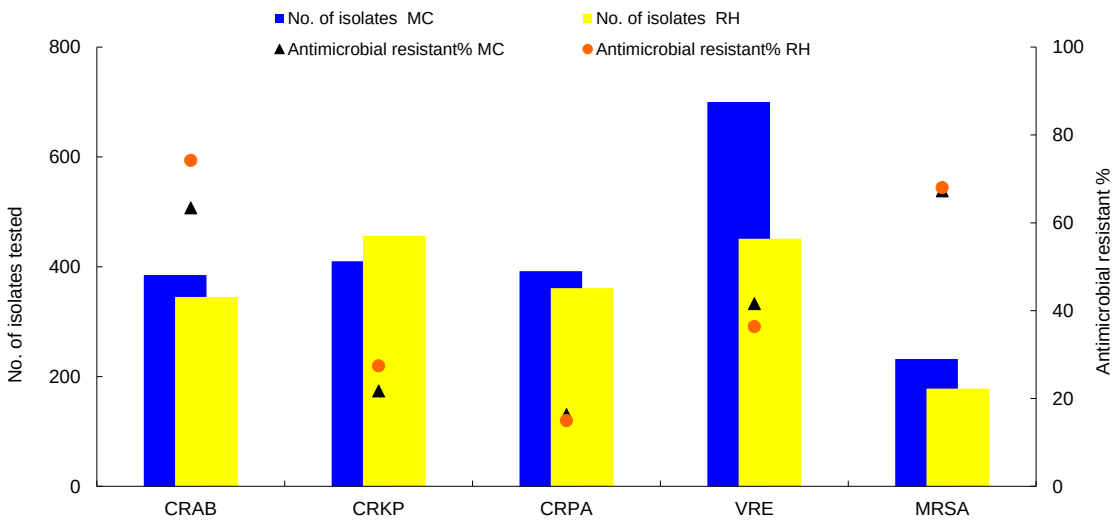
2. NOS: not otherwise specified.

Table 14 Common pathogens of healthcare-associated infections in the ICUs of regional hospitals, 2016

Pathogens	Total		Types of Infection									
			Urinary tract		Bloodstream		Pneumonia		Surgical site		Others	
	Rank	No.	Rank	No.	Rank	No.	Rank	No.	Rank	No.	Rank	No.
Klebsiella pneumoniae	1	518	3	163	1	182	3	124	5	19	2	30
Escherichia coli	2	517	1	365	8	88	8	26	2	25	7	13
Candida albicans	3	506	2	344	5	99	7	28	8	10	5	25
Pseudomonas aeruginosa	4	410	5	130	10	77	1	141	1	32	2	30
Acinetobacter baumannii	5	398	9	54	2	177	2	126	9	9	1	32
Enterococcus faecium	6	251	4	141	7	93	24	1	10	7	9	9
Other *Candida* spp. or NOS	7	226	13	14	3	112	4	63	6	15	6	22
Staphylococcus aureus	8	224	6	122	6	95	17	2	18	1	14	4
Enterobacter species	9	182	11	37	9	79	6	35	2	25	12	6
E.cloacae		130		25		63		23		15		4
Other *Enterobacter* spp. or NOS		52		12		16		12		10		2
Enterococcus faecalis	10	181	7	86	12	64			4	23	10	8
Others		1,144		297		554		130		75		88
Total		4,557		1,753		1,620		676		241		267

Note: 1. isolates of the same species of bacteria, regardless of antimicrobial susceptibility pattern, are counted only once per patient per infection. That is, no duplicate isolates are included.

2. NOS: not otherwise specified.



Note: 1. "Antimicrobial resistant %" indicates the % of Isolates with susceptibility tested to be intermediate or resistant to the antimicrobial specified.

2. CRAB: carbapenem (imipenem or meropenem)-resistant *Acinetobacter baumannii*; CRKP: carbapenem (imipenem, meropenem, or ertapenem)-resistant *Klebsiella pneumoniae*; CRPA: carbapenem (imipenem or meropenem)-resistant *Pseudomonas aeruginosa*; VRE: vancomycin-resistant *enterococci* (*Enterococcus faecalis*, *Enterococcus faecium*...etc.); MRSA: oxacillin-resistant *Staphylococcus aureus*.

Figure 3 Antimicrobial resistances of selected pathogens of healthcare-associated infections in the ICUs of medical centers(MC) and regional hospitals(RH), 2016