BBV and MRO Infections In Haemodialysis: Proposal for Screening Guideline

Meg Jardine, on behalf of

Eugene Athan, Denise Campbell, Robert Commons, Janak de Zoysa, Nicole Gilroy, Julianne Green, Belinda Henderson, Martin Howell, Rhonda Stuart, Carolyn van Apps, Muh Geot Wong
Friday’s emails: medical and popular press

Physician’s First Watch
David G. Fairchild, MD, MPH, Editor-in-Chief

In This Issue: February 27, 2015

- Effort Aims to Treat Cancer Based on Gene Mutations, Not Cancer Type
- ACIP Recommends Serogroup B Meningococcal Vaccines in High-Risk People
- FDA Asking Duodenoscope Makers to Prove That Their Disinfection Methods Work
- Nosocomial Transmission of Hepatitis C
- New Combo Antibacterial Approved for Complicated Intra-Abdominal Infections, UTIs

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Nosocomial Transmission of Hepatitis C

By Cara Adler
Edited by André Sofair, MD, MPH, and William E. Chavey, MD, MS

Transport of potentially contaminated items between operating rooms was the likely cause of hepatitis C virus transmission in two independent incidents, according to an MMWR article.

In one incident, reported in New Jersey in 2010, transmission likely occurred when an HCV-negative patient received an injection from an anesthesia cart that had just been used for an HCV-positive patient in a different operating room (needles, syringes, and vials had not been re-used). The hospital had no policies for disinfecting carts between patients.

In the other incident, reported in Wisconsin in 2011, transmission likely occurred when a kidney perfusion machine used in "a blood-rich environment" during transplantation to an HCV-infected patient was moved into an HCV-negative patient's operating room without being disinfected.

In both incidents, molecular analysis of HCV strains from the two patients showed 100% identity.

Although “the definitive mode of HCV transmission was not established,” the incidents highlight the importance of adherence to infection control practices and suggest that healthcare-associated transmission be considered when evaluating acute HCV infections, the authors conclude.

MMWR article (Free)
CDC recommendations for prevention and control of HCV disease (Free)

FDA Asking Duodenoscope Makers to Prove That Their Disinfection Methods Work

By Kelly Young
Edited by André Sofair, MD, MPH, and William E. Chavey, MD, MS

The FDA has asked manufacturers of duodenoscopes — which have transmitted carbapenem-resistant Enterobacteriaceae (CRE) in several hospitals — to show proof that their recommended methods of disinfecting the devices actually work, the New York Times reports.

The agency told the Times that it has never reviewed data on the manufacturers’ protocols for decontaminating the devices.

A CDC team found that even after a hospital cleaned its duodenoscopes per the manufacturer’s recommended procedures, the devices were still contaminated.

Following CRE outbreaks, two hospitals in Los Angeles and the Chicago area have switched to sterilization with ethylene oxide and have not had any more CRE cases since. The FDA is hesitant to recommend routine ethylene oxide sterilization because the gas can be toxic to workers.

New York Times story (Free)
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MMWR article (Free)

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New York Times story (Free)
Friday’s emails continued

GP reprimanded after death of detox patient
A SYDNEY GP has been barred from treating opioid addicts after the death of a former journalist who offered favourable “PR” in return for a rapid detox at a cheap rate.

Do you prefer cracked or clean?
HAND hygiene campaigns are important for infection control but the resultant dermatitis may cause more harm than good.

Medical Observer wants your suggestions
UNDER the banner ‘If I Ruled Medicare’, the print edition of Medical Observer last month began running doctors' suggestions on the ways the government could shake up health.
Do you prefer cracked or clean?

27th Feb 2015
Sheshtyn Paola all articles by this author

HAND hygiene campaigns are important for infection control but the resultant dermatitis may cause more harm than good.

A UK study shows that hand washing initiatives in healthcare workplaces may be behind increasing numbers of doctors and nurses developing irritant contact dermatitis.

The study looked at work-related cases of contact dermatitis reported by UK dermatologists between 1996 and 2012.

In 2012 there were around 4.5 times as many reports in healthcare workers attributed to hand hygiene procedures as in 1996. In two control groups of other workers, the number of cases declined over the same period.

The authors noted that studies have previously identified that infections such as MRSA can remain present for longer on damaged and broken skin.

Healthcare workers with irritant contact dermatitis were also less likely to comply with hand hygiene procedures, they noted.

Campaigns to reduce these infections have been very successful and many lives have been saved. However, we need to do all we can to prevent irritation among these frontline workers," said lead researcher Dr Jill Stocks, a research fellow at the University of Manchester's Centre for Occupational and Environmental Health.

"Obviously we don't want people to stop washing their hands, so more needs...
Illustrations of universal precautions failures

Nosocomial spread of BBV and MROs

Efficacy of prevention measures

Potential harms of prevention measures

The haemodialysis process tests systems
Screening Guideline for Haemodialysis

Objective of screening: reduce nosocomial disease transmission

- What is the evidence on benefits of screening?
- What is the evidence on harms of screening?
- For what should you screen?
- When should you screen?

Acknowledgement of variation in practice
Guideline scope

• Request for a new guideline suggested the following scope
  – The necessity of viral and bacterial screening of patients on dialysis
  – The frequency of screening if this is found to be useful
  – Treatment and isolation regimens needed
  – The need to rescreen if moving between units

• Process
  – Guideline request
  – Assemble team
  – Scope
  – Literature search terms
  – Draft guidelines
  – Feedback
  – Finalise guidelines
Today

• The scale of the problem: preliminary look
• Outline development of a guideline
  – Defining the group
  – Defining the scope
  – Parallel patient/patient advocate input process
• Group feedback/input
HBV – EU and USA

BMC Medicine

Research article

Patient to patient transmission of hepatitis B virus: a systematic review of reports on outbreaks between 1992 and 2007
Simone Lanini*, Vincenzo Puro†, Francesco N Lauria, Francesco M Fusco, Carla Nisii and Giuseppe Ippolito

Address: Istituto Nazionale per le Malattie Infettive, Lazzaro Spallanzani-Roma, Via Portuense, 00149 Rome, Italy
Email: Simone Lanini* - lanini@inmi.it; Vincenzo Puro - puro@inmi.it; Francesco N Lauria - lauria@inmi.it; Francesco M Fusco - fusco@inmi.it; Carla Nisii - nisii@inmi.it; Giuseppe Ippolito - lppolito@inmi.it
* Corresponding author †Equal contributors

- 33 outbreaks
- 471 patients, including 16 fatal cases
- Dialysis units involved in 30.3% of outbreaks
### Table 1: Summary of the most frequent transmission pathways and most frequent healthcare settings involved.

<table>
<thead>
<tr>
<th>Healthcare setting</th>
<th>Multi-vials</th>
<th>Capillary blood sampling</th>
<th>Multiple deficiencies in standard precautions</th>
<th>Transvenous biopsy</th>
<th>Blood products</th>
<th>Undefined</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis</td>
<td>5</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Medicine</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Nursing home</td>
<td>-</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Surgery</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Outpatient clinics</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>9</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>33</td>
</tr>
</tbody>
</table>
HCV - USA

- HCV prevalence
  - Haemodialysis patients 8-10%
  - General population 1 – 1.5%
- Multiple HCV infection outbreaks in US Dialysis units 2008-2011
  - Associated with at least 46 new infections
Closer to home....

Blood-borne viruses in the haemodialysis-dependent population attending Top End Northern Territory facilities 2000–2009

JANE DAVIES, ZULFIKAR JABBAR, FIZZA GAGAN and ROBERT W BAIRD

Departments of Infectious Diseases, Nephrology and Microbiology, Royal Darwin Hospital, Darwin, Northern Territory, Australia

- Retrospective review, 2000-2009
- n=440, 84.3% Indigenous, 55.4% female
Top end

• HBV
  – Past infection 42.7%
  – HBsAg pos. 8.9%
  – 3 patients seroconverted
    0.1/100 patient yrs
    =0.0006/dialysis episode

• HTLV 2.2%

• HCV Ab pos. 1.6%

• HIV 0%

Effects of “isolating hemodialysis” on prevention of methicillin-resistant \textit{Staphylococcus aureus} cross-infection in a hemodialysis unit

E. Osono$^{1,2,3}$, M. Takahashi$^2$, S. Kurihara$^1$, K. Ohwada$^1$, Y. Sakurai$^1$, N. Onoda$^1$, M. Takeuchi$^1$, H. Yoneshima$^1$, N. Hayama$^3$, Y. Iino$^3$, M. Saji$^4$, R. Shikita$^4$, H. Takahashi$^2$ and H. Ohkuni$^5$

$^1$Department of Nephrology, Kasukabe Shuwa Hospital, Saitama, 
$^2$Department of Microbiology and Immunology, 
$^3$Second Internal Medicine and 
$^4$Committee for Infection Control of First Hospital, Nippon Medical School, Tokyo, 
and $^5$Institute for Gerontology, Nippon Medical School, Kanagawa, Japan
Intervention

Table 1. A guideline for prevention of methicillin-resistant *Staphylococcus aureus* (MRSA) outbreak among hemodialysis patients in Kasukabe Shuwa Hospital.

- Barrier isolation of hemodialysis patients with MRSA by separated rooms and the gown technique (*isolating hemodialysis*)
- Isolation of hospitalized patients with MRSA according to preventive protocol for hospital outbreak [Mulligan et al. 1993]
- Seasonal surveillance of MRSA carriers in all hemodialysis patients for early detection. When MRSA is isolated, subject is followed-up at least twice a month 4 times consecutively until relief from MRSA.
- Treatment for MRSA colonization
  - skin/wound: gentian violet (GV) ointments [Saji et al. 1994]
  - throat/nasal: povidone-iodine gargle and nasal GV ointment or mupirocin ointment
  - others: depend on cases

Frequency MRSA infection after 2.5yrs of intervention

Pre-intervention: 4.5%  
Post-intervention: 2.9%
VRE – Ireland in 2004

Implications of colonization of vancomycin-resistant enterococci (VRE) in renal dialysis patients. Learning to live with it?


Setting: Retrospective review triggered by outbreak in ICU. Initial investigations revealed ICU some affected patients transferred from renal service
VRE in the Irish outbreak

- 13% of unit colonised (60 of 451), 2 required systemic antibiotics
- Intervention included cohorting screen-positive patients
  - Haemodialysis VRE+ patients dialysed at night followed by cleaning
- Continued positive environmental swabs despite implementation of cleaning
- Recommended control measures eventually abandoned

Humphreys JHI 2004. 58, 28-33
Vancomycin-resistant enterococci colonization does not increase mortality in end-stage kidney failure: a case–control study

S.E. Garner\textsuperscript{a,\,*}, K.R. Polkinghorne\textsuperscript{b,\,*}, D. Kotsanas\textsuperscript{a}, P.G. Kerr\textsuperscript{b,\,*}, T.M. Korman\textsuperscript{a,\,*}, R.L. Stuart\textsuperscript{a,\,*}

\textsuperscript{a} Department of Infectious Diseases, Monash Medical Centre, Monash Health, Victoria, Australia
\textsuperscript{b} Department of Nephrology, Monash Medical Centre, Monash Health, Victoria, Australia
\textsuperscript{c} Department of Medicine, Monash University, Victoria, Australia

Garner JHI 2013. 85, 289-296
VRE @ Monash: steady state

21,744 VRE negative screening swabs in 12,310 potential control subjects. 570 VRE-positive potential case subjects 1 Jan 2000 to 31 Dec 2009

1617 end-stage kidney failure Monash Medical Center subjects in ANZDATA registry 2000-2010

416 cases and 11,237 controls excluded as not in ANZDATA registry dataset

154 cases and 1073 controls matched to ANZDATA registry dataset

Final study cohort: 271 subjects, 134 cases and 137 controls

Garner JHI 2013. 85, 289-296
VRE @ Monash: steady state

• Retrospective case-control
• 2000-2010
• N=134 cases, n=137 controls
• Outcomes
  – Mortality RR 1.14 (0.78-1.69) p=0.49
  – Length of stay 7.3d v 4.1, p<0.001
  – Number of admissions 9.3 v 8.3, p=0.78
  – 12 clinically significant isolates
  – 8 patients of 134 VRE colonised progressed to clinically meaningful infection

Garner JHI 2013. 85, 289-296
VRE meta-analysis

Vancomycin-Resistant Enterococci Colonization Among Dialysis Patients: A Meta-analysis of Prevalence, Risk Factors, and Significance

Ioannis M. Zacharioudakis, MD, Fainareti N. Zervou, MD, Panayiotis D. Ziakas, MD, PhD, Louis B. Rice, MD, and Eleftherios Mylonakis, MD, PhD


From the Infectious Diseases Division, Warren Alpert Medical School of Brown University, Rhode Island Hospital, Providence, RI.
VRE prevalence

6.2%
# Predictors and associations of VRE colonisation

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Studies and events identified (n)</th>
<th>OR of VRE colonisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving vancomycin</td>
<td>5 studies, 1251 events</td>
<td>5.15 (1.56, 17.02)</td>
</tr>
<tr>
<td>Receipt of non-vancomycin antibiotics</td>
<td>5 studies, 1435 events</td>
<td>2.92 (0.99, 8.55)</td>
</tr>
<tr>
<td>Receipt of any antibiotic</td>
<td>5 studies, 1591 events</td>
<td>3.62 (1.22, 10.75)</td>
</tr>
<tr>
<td>Prior hospitalisation</td>
<td>7 studies, 1848 events</td>
<td>4.55 (1.93, 10.74)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Studies and events identified (n)</th>
<th>OR of VRE infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>VRE colonisation</td>
<td>4 studies, 461 events</td>
<td>21.62 (5.33, 87.59)</td>
</tr>
</tbody>
</table>

Zacharioudakis *AJKD* 2014, 65(1):88-97
VRE: Number needed to harm

Treat with any antibiotic 12
Treat with non-vanc. antibiotic 16
Treat with vancomycin 8

1 VRE colonisation for every 7 patients hospitalised during previous year

Today’s talk

• The scale of the problem: preliminary look
• Outline development of a guideline
  – Defining the group
  – Defining the scope
  – Parallel patient/patient advocate input process
• Group feedback/input
Guideline group

Eugene Athan (ID physician, Co-convenor, Geelong)
Meg Jardine (Nephrology physician, Co-convenor, Sydney)

Robert Commons (ID physician, Melbourne)
Janak de Zoysa (Nephrology physician, Auckland)
Nicole Gilroy (ID physician, Sydney)
Belinda Henderson (ID CNC, Brisbane)
Julianne Green (Dialysis NUM, Sydney)
Rhonda Stuart (ID physician, Melbourne)
Carolyn van Apps (Nephrology physician, Brisbane)
Muh Geot Wong (Nephrology physician, Sydney)

Martin Howell (CARI)
Denise Campbell (CARI)
Scope: What is not in the guideline

• Epidemic infections
  – Eg. Respiratory viruses, acute gastroenteritis

• Ubiquitous colonisations
  – Eg. HSV1

• Etc etc etc
# Topics 1 and 2: Screening (BBV and MROs)

What are the benefits and/or harms associated with screening for blood borne viruses and multiple resistant organisms (including culture, molecular methods/NAAT, serological testing, and frequency of testing)?

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention/Indicator</th>
<th>Comparison/Control</th>
<th>Outcome(s)</th>
<th>Study Type(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemodialysis patients</td>
<td>Screening and surveillance/monitoring for:</td>
<td>Alternate approaches to screening and surveillance including no screening</td>
<td>Rate of detection</td>
<td>Controlled trials/studies</td>
</tr>
<tr>
<td></td>
<td>a) Blood borne viruses (HCV, HBV, HIV)</td>
<td></td>
<td>Rate of transmission to other patients and/or staff</td>
<td>Prospective cohort</td>
</tr>
<tr>
<td></td>
<td>a) Infectious organisms (including but not limited to, MRSA, VRE, MRAB, MRPA, CRE, ESBL)</td>
<td></td>
<td>Hospitalisations</td>
<td>Case-control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospital bed days</td>
<td>Historical control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mortality</td>
<td>Diagnostic test studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychosocial (stigma, isolation)</td>
<td>(NB data to include response to a positive identification. Potentially we will analyse outcomes according to the type of response – subgroup analysis. Data to include background prevalence)</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Quality of life</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Impact on clinical contact</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Impact on delivered services (OT, allied health, etc.)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Impact on clinical decisions (e.g. vaccination, antibiotic prescribing)</td>
<td></td>
</tr>
</tbody>
</table>

What are the benefits and/or harms associated with screening for blood borne viruses and multiple resistant organisms (including culture, molecular methods/NAAT, serological testing, and frequency of testing)?
Topics 3: Transmission based precautions

1. Does the use of PPE reduce the transmission of infectious diseases in HD units?
2. What methods of management of HD machines prevent transmission of infections between patient?

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention/Indicator</th>
<th>Comparison/Control</th>
<th>Outcome(s)</th>
<th>Study Type(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemodialysis patients</td>
<td>Use of PPE (including but not limited to gloves, gowns, aprons) or of greater PPE</td>
<td>Control/ lesser PPE</td>
<td>Rate of detection</td>
<td>Systematic review</td>
</tr>
<tr>
<td>Patients in other health care settings</td>
<td></td>
<td></td>
<td>Rates of transmission to other patients and/or staff</td>
<td>Controlled trials</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prospective cohort studies</td>
</tr>
<tr>
<td>Haemodialysis patients</td>
<td>Interventions with the intent of reducing the transmission of BBV and MRO infections</td>
<td>Comparator/ control/ reuse</td>
<td>Nosocomial infection rates</td>
<td>Controlled trials</td>
</tr>
<tr>
<td></td>
<td>including the use of sterilising processes, avoidance of practices of reusing components.</td>
<td></td>
<td>Rates of transmission to other patients and/or staff</td>
<td>Prospective cohort studies</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Case-control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Retrospective</td>
</tr>
</tbody>
</table>

It is not expected we will find substantial evidence in the dialysis population for topics 3-4. We will update the search used for the NHMRC (2010) Australian Guidelines for the Prevention and Control of Infection in Healthcare.
# Topics 4: Environmental controls – cleaning and disinfection

Which environmental cleaning/disinfection agent or procedures (including frequency of cleaning) have the greatest efficacy against transmission of bacteria and blood borne viruses?

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention/ Indicator</th>
<th>Comparison/ Control</th>
<th>Outcome(s)</th>
<th>Study Type(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haemodialysis units</td>
<td>Environmental cleaning, disinfection agent or Procedures</td>
<td>Comparator/control</td>
<td>Rates of transmission to other patients and/or staff.</td>
<td>Systematic reviews</td>
</tr>
<tr>
<td>Other health care settings</td>
<td>(incl. agents/procedures used predominantly for staff, for patients, for HD machines, for inanimate objects and environmental surfaces)</td>
<td></td>
<td>Rate of detection</td>
<td>Controlled trials</td>
</tr>
<tr>
<td>Ward versus outpatient setting</td>
<td></td>
<td></td>
<td>Environmental contamination rates</td>
<td>Prospective</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case-control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Historical</td>
</tr>
</tbody>
</table>

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Today’s talk

• The scale of the problem: preliminary look
• Outline development of a guideline
  – Defining the group
  – Defining the scope
  – Parallel patient/patient advocate input process
• Group feedback/input
Patients and caregivers recruited from Concord Hospital and via KHA Australia

**Workshop 1**
What are CPGs?
What are the most important issues for dialysis patients?

**Workshop 2**
Review draft guideline

**Topics that should be included in ID guidelines.**
Important outcomes.

**Do the guidelines reflect patient preferences and values?**
How should the guideline be put into practice?

**BBV/MRO Guideline Working Group**
Ensure topics align with patient needs

Write draft guideline

Modify guidelines to reflect workshop findings
Develop implementation plan
Dear member

We would like to invite patients who are undergoing haemodialysis and have been screened for an infectious disease or their carers to provide input on topics and outcomes for inclusion in clinical practice guidelines on the screening and management of infectious diseases in dialysis units. The guidelines are being developed to provide doctors with recommendations based on research evidence about the treatment and care of patients who are undergoing dialysis and need to be screened for infectious diseases.

This will involve attending two consultation workshops that run for 2-3 hours each. The workshops will be conducted in a central and accessible venue in Sydney.

The feedback from patients and carers can help to ensure that patient and carer perspectives and priorities are included in these clinical practice guidelines.

If you would like to know more about this project, please contact the Project Coordinator, Ms Denise Campbell on (02) 9845 1477 or email: denise.campbell@health.nsw.gov.au

Regards

Kidney Health Australia
Today’s talk

• The scale of the problem: preliminary look
• Outline development of a guideline
  – Defining the group
  – Defining the scope
  – Parallel patient/patient advocate input process
• Group feedback/input
• Is scope right?
• Are the questions right?
• Other

• Feedback: mjardine@georgeinstitute.org.au