



DNT WORKSHOP

OPTIMAL AND
EQUITABLE KIDNEY
HEALTH FOR ALL

26-28 MARCH
2023

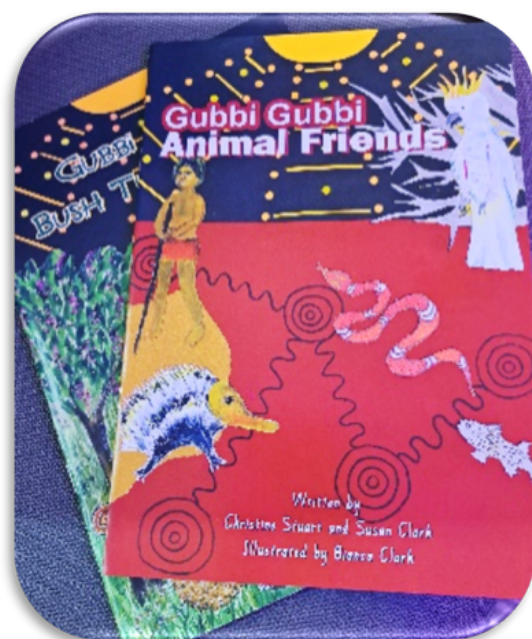


INTRODUCTION

Associate Professor Peter Mount, chair of the ANZSN Policy and Quality Committee (PQC) and LoC, welcomed guests and participants to DNT 2023 and highlighted some of the achievements arising from the previous virtual DNT in September 2021.

These included;

- The publication of the ANZSN Aboriginal and Torres Strait Islander, and Māori Health Statement in March 2022 to coincide with the 2022 World Kidney Day
- Equity in Kidney Care Position statement, launched in October 2022, at the ANZSN Annual Scientific Meeting in Sydney
- Formation of the joint ANZSN-TSANZ Kidney Transplant Information/Education Working Group, which is working to establish a framework for better and more standardised information for kidney transplant recipients



Aunty Christine Stuart extended a warm welcome to country on behalf of the Gubbi Gubbi people and made the generous donation of two books which are now archived in the ANZSN office.

ANZSN acknowledges the Traditional Custodians of Country throughout Australia, recognises their unique cultural and spiritual relationships to the land, waters and seas and their immense contributions to society, and pays respects to Ancestors and Elders, past and present. ANZSN is committed to supporting the broad intent and key strategies contained in the Uluru Statement from the Heart, for Aboriginal and Torres Strait Islander peoples. ANZSN acknowledges and respects iwi and hapū as tangata whenua of Aotearoa and is committed to upholding the principles of Te Tiriti o Waitangi (the Treaty of Waitangi). ANZSN strives to actively foster a strong relationship with Māori, support Māori members and improve the kidney health of Māori patients and their whānau as outlined by the New Zealand Ministry of Health.

To read our full statement on Indigenous Health [click here](#).

EQUITY CHALLENGES IN KIDNEY CARE

Chaired by **Dr Scott Crawford** and **Dr Kelly Lambert**.

A/Professor Jacqui Hughes – Indigenous Transplant Equity

A/Professor Rachael Walker – Rural/remote Equity Challenges

Dr Kamal Sud – Equity Challenges for Cultural and Linguistically Diverse Patients

Dr Anita Van Zwieten - Socioeconomic Factors and Equity challenges

Dr Melanie Wyld – Sex and Equity Gender Challenges

Speakers provided a brief snapshot touching on many aspects of inequity in Kidney Care. This session set the scene for much of the discussion over the next two days. Speakers provided an understanding of the history of inequities and the role of individual causes of inequity. One of the main topics raised in the panel discussion was intersectionality and the role of multiple factors of inequity on patient outcomes.

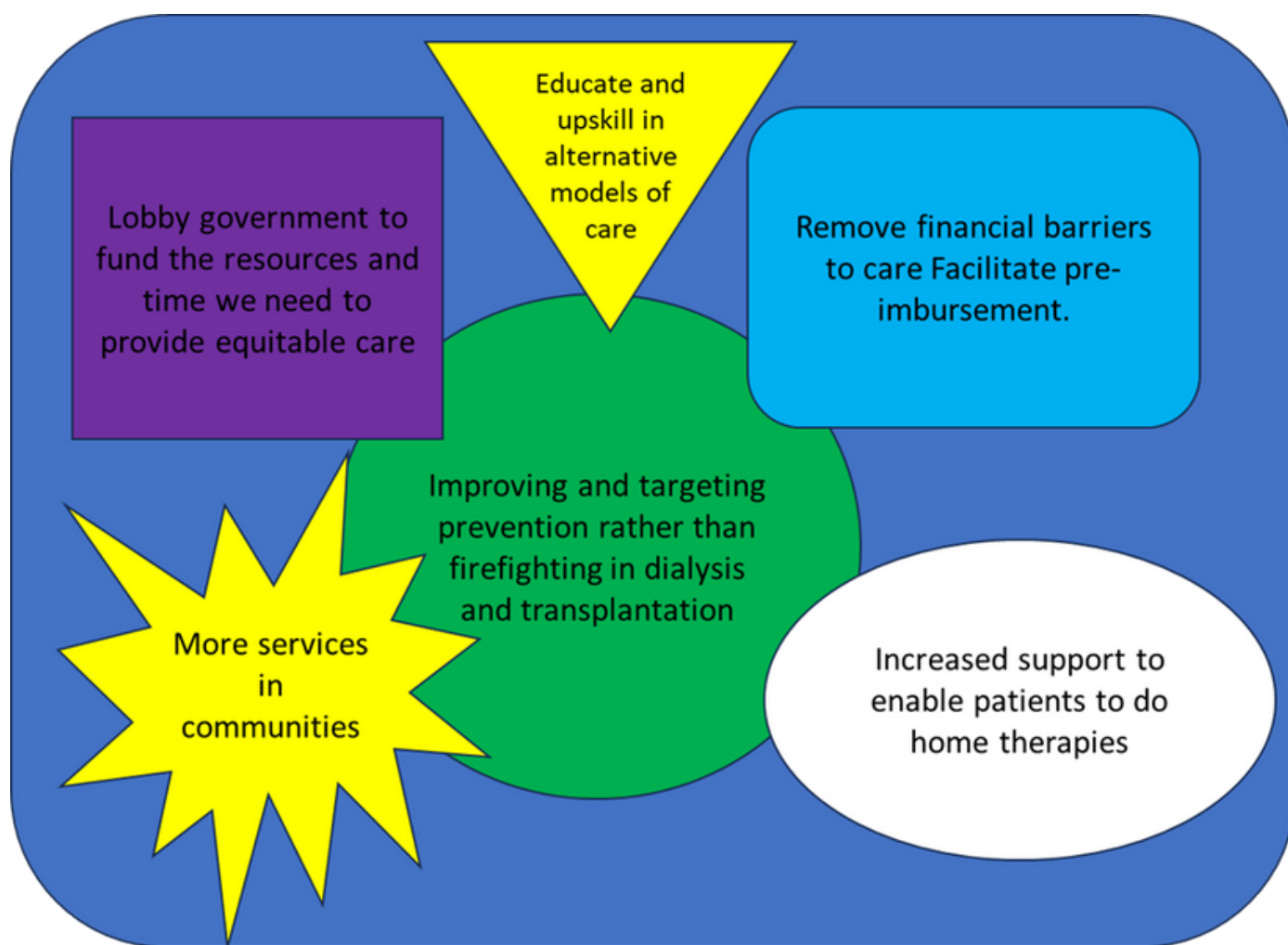
The audience and speakers acknowledged the ongoing challenges and barriers to addressing these issues but also highlighted successes. These included the work of the National Indigenous Kidney Transplant Taskforce (NIKTT), Development of apps for culturally and linguistically diverse (CALD) patients and families and the ongoing research to address these inequities.

Participants were invited to give suggestions on ways to address inequities in kidney care, some of which are presented in Figure 1.



POTENTIAL ACTION POINTS FOR ANZSN

- Add equity as a KPI for both units and the Society
- Design health structures that remove barriers for rural, regional and remote patients
- Promote research and reporting on the impacts of ethnicity
- Ensure research and trials include and analyse the impact of sex and gender on kidney care and health outcomes
- Advocate for reducing the structural and financial barriers to equitable care for lower SES patients





CONSUMER ENGAGEMENT TO OPTIMISE KIDNEY CARE

Co-Chairs: **Michael Papesch, Prof Karen Dwyer, Traci Stanbury**

Lucy McIntosh – Kidney PREMs: Gaining a perspective of patient experience of kidney care in the UK

Nicole Scholes-Robertson, Andrea Matus Gonzalez – Patient Centred Outcomes and a Core Outcome Set for CKD. What matters to patients and caregivers? SONG-CKD

A/Prof Rachael Walker – What matters and what can be improved: A consumer perspective from the literature

Maria O'Sullivan – Kidney Health 4 Life: A pilot project

Dr Shyamsundar Muthuramalingam – Models for patient engagement

Deon York – Embedding what matters: A code of expectations for consumers and whanau

PQC Consumer representative Michael Papesch introduced the session and outlined the many ways in which patients are instrumental in the success of their kidney health journey as part of a self-management partnership with renal clinicians. The importance of consumer involvement in kidney care has long been acknowledged, however the challenge remains on how to support patients so that they can live their lives well, make their full contribution to their care, and have a meaningful input into the design and delivery of services.

These factors underpin a patient's ability to fully contribute to the self-management of kidney disease. As renal specialists respond best to credible data and evidence, using recognised analytical and statistical frameworks, the session outlined a range of evidence of what matters most to patients, and how to engage patients in the design and delivery of their care.

The session began with arguably the international benchmark for kidney PREMs – looking at the qualitative data from the UK PREMs – and then explored the known international and Trans-Tasman evidence on what mattered for patients to support their self-management efforts. The session concluded by looking at models for substantive patient involvement.

Themes/issues identified in the session as being key to patients included:

- Managing kidney disease – and the medical consequences of kidney disease (such as cardiovascular and mortality risks) were central concerns for patients. Gaining dependable knowledge about the impact of kidney disease and the treatment/care options available, in ways that are accessible for individual patients, is crucial
- But equally important was life participation: the “ability to participate in meaningful activities of daily living, including work, study, and social recreational activities.” The range of factors that impact on life participation include: fatigue, pain, access to care (availability of care, getting timely appointments), continuity of care, tailoring care to the needs of patients, and managing the economic and financial consequences of kidney disease.

The session outlined several care models and patient support initiatives that could address these challenges and thus enable better patient self-management of their disease. Underpinning these improvements is developing a meaningful and sustainable patient voice in the design and delivery of their care. Models for doing so were highlighted in the final part of the session.

PREMs are a way to get real-time information on the patient experience and pain-points, across both system and centre-level issues. 73% of respondents to a specific polling question wanted patient reported measures in place within 1-2 years. In terms of using PREMs results, there are a range of approaches to formal patient engagement processes, from “consult patients” (the least engaging) through to “collaborate with patients” or “empower patients.” Participants wanted to move from “consult” as the most common engagement process (at 35%) to either “collaborate” (41%) or “empower” (39%).

POTENTIAL ACTION POINTS FOR ANZSN

- Develop a proposal for PREMs implementation across Australia and New Zealand and ascertain viability.
- Development of resources to assist units and health services to increase patient collaboration and empowerment.
- Work with consumer organisations to improve patient self-management programs.
- Continue advocacy on matters relevant to patient experience.



INNOVATION AND IMPROVEMENT IN DIALYSIS

Chairs **Dr Dev Jegatheesan and Dr Anita Van Zwieten**

A/Professor William Majoni -
Haemodialysis Capacity Crisis -
Learnings from the Northern Territory

A/Professor Yeungjee Cho -
Peritoneal Dialysis Update

Dr Martin Wolley - Incremental
Haemodialysis Update

**A/Professor Kevin Polkinghorne and
Dr Sradha Kotwal** - Vascular Access
debate: Are Catheters Really That Bad?

Haemodialysis Capacity Crisis – Learnings from the Northern Territory

The session began with a humbling presentation from Professor William Majoni on the dialysis capacity crisis in the Northern Territory (NT).

The current kidney replacement therapy (KRT) modality distribution in the NT is not optimised to promote patient flourishing and adherence to treatment. The largest proportion of patients are on satellite HD, with lower proportions on community dialysis, home dialysis and with transplants. This is likely to result in lower adherence, higher hospitalisation rates and higher costs as well as dislocation from Country with adverse impacts on social and emotional wellbeing.

Key proposed solutions to address these issues in the NT: increased training and recruitment (especially of First Nations staff), increased resources, better modelling of future demand, repeal of Dialysis Cancellation policies, establishment of programs to facilitate access to home dialysis and transplantation during the transition into KRT, advocacy to government from ANZSN and other key bodies, recruitment and retention of renal nurses, establishment of strong public-private partnerships, and consumer partnerships in policy and service development.

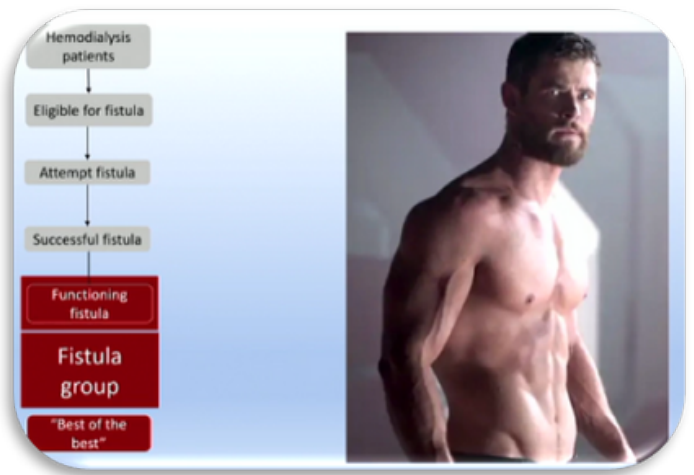
Incremental HD

Incremental Haemodialysis (HD) may be a potential solution to abrogating the HD capacity crisis across ANZ. Incremental HD may allow gentle transition onto dialysis, involves less time on dialysis and reduces costs to patients and providers alike. Potential benefits include preservation of residual kidney function, fewer vascular access issues and improved quality of life. The currently recruiting INCH-HD trial will inform the future place of Incremental HD.

Peritoneal Dialysis

Urgent start peritoneal dialysis (USPD) (starting PD within 2 weeks of catheter insertion) has been shown to be an effective and safer alternative to urgent start HD with a central venous catheter. Strategies to increase the uptake of USPD include dedicated training of providers for USPD catheter insertion (nephrologists, radiologists, surgeons) and establishing unit USPD 'champions' to co-ordinate care and education. According to DNT polling, only 6% reported widespread use of USPD in place of catheter-facilitated HD in their units, with 53% reporting inconsistent use, and 34% reporting inability to offer due to lack of infrastructure.

Assisted PD programs in North America and Europe have proven to be successful, with hospitalisation, infection and survival outcomes similar to in-centre HD and/or self-PD. Innovative funding strategies are urgently required to facilitate assisted PD in ANZ. This was endorsed by attendees too, with polling results finding that 80% of respondents agreeing that there is a place for formalised assisted peritoneal dialysis in ANZ. Incremental PD may be a more appropriate, attractive and effective way for people to commence dialysis. Overall, this strategy may reduce dialysis burnout, improve retention on PD and reduce rates of transfer to HD.



Vascular Access Debate – are catheters really that bad?

There were no winners in the debate about catheters but it is clear that catheters remain an essential tool in the nephrology toolbox. If all patients had veins like Thor vascular access would never be a problem.

POTENTIAL ACTION POINTS FOR ANZSN

- Advocacy for immediate action by the Northern Territory government to address the dialysis capacity crisis. ANZSN have engaged with the Northern Territory government on this issue.
- Support research and evidence-based guideline development for the appropriate clinical use of incremental dialysis, including support for the INCH-HD trial.
- Advocate to include urgent start peritoneal dialysis catheter insertion in nephrology training programs.

OVERCOMING INEQUITIES IN TRANSPLANTATION

Chairs: **Dr Melanie Wyld, Dr Amanda Mather, Professor Rob Walker**

A/Professor Darren Lee - Information equity: Improving information for transplant recipients

Professor Angela Webster - Access to the transplant waitlist – addressing variation

Professor Kate Wyburn - Allocation algorithm – changes and updates

Gary Torrens, Brett Mooney - Approaches to increasing First Nations access to live and deceased donor kidney transplantation

Dr Scott Crawford - One Day Renal Transplant Workup

Information equity: Improving information for transplant recipients

Polling at several DNT meetings has shown support for a national approach to consent for transplant waitlisting. This resulted in formation of a joint ANZSN-TSANZ working group.

The working group has determined that a unified ANZ consent form for kidney transplantation or kidney transplant waitlisting was not currently recommended. Reasons for this decision included the fluid and ongoing nature of education and consent, long lead time from waitlisting and transplantation, and a concern about excessive focus on risks rather than the benefits of transplantation compared to remaining on dialysis. The working group has reviewed existing education materials, in particular those developed by Kidney Health Australia. The working group plans to complete a guidance document outlining a framework for transplant assessment, education and communication. The working group also aims to provide a list of recommended reference transplant education materials, and to promote awareness and advocate for use of the guidance documents.



Access to the transplant waitlist – addressing variation

In Australia, kidney transplant waitlisting time starts with commencement of dialysis rather than completion of transplant workup. Once on the waitlist patients may cycle on and off the waiting list due to illness or comorbidities. However, how long patients spend on or off the waiting list is not always equitable. Extended periods spent off the waiting list may result in patients becoming too unwell to receive a transplant or dying from the effects of kidney disease before receiving a kidney. Adjusted data indicate that when men and women cycle off the list, males get back on the list more often than females and that this is exacerbated by ethnicity. There is also significant variation in state-based waiting lists. Should waitlist allocation be adjusted to remove inequities?

Allocation algorithm – changes and updates

The kidney transplant allocation algorithm determines the equitable distribution of a finite and precious resource and also the optimal utility of the available organs. The updated algorithm implemented in 2021 takes more into account sensitisation, age, donor/recipient “quality” matching (based on KDPI and EPTS) and homozygous DR matching. There is an aim to align states regarding ABO, waiting vs matching, and paediatric priority. The new algorithm has resulted in improved transplant rates for sensitised patients, better matching for younger patients, better donor/recipient matching and no obvious unintended adverse consequences. It also resulted in a reduced transplant rate for older patients and those with a PRA of 80-95% and more interstate shipping of kidneys.

Approaches to increased First Nations access to Live and Deceased Kidney Transplantation

Between 1969-2019 only 171 of 4754 (3.6%) Transplants in Queensland were in First Nations people.

As a result of these findings the Equity improvement project was implemented. Actions included, implementation of recommendations from peak bodies, appointment of indigenous staff, outreach education, outreach clinics and indigenous reference groups.

First Nations kidney health worker and clinical nurse consultant Garry Torrens and Brett Mooney were hired to lead this project. Their role has a dual purpose designed to provide culturally appropriate engagement and support of Aboriginal and Torres Strait Islander patients accessing kidney transplantation as a treatment option and supporting patients with chronic kidney disease. The position also supports and provides cultural leadership for staff across the department, strengthening the department’s engagement with Aboriginal and Torres Strait Islander patients. Identified keys to improving transplant wait listing in First Nations people are workforce, engagement, and consultation.

To make projects such as these sustainable and scalable it is necessary to grow, encourage and upskill an indigenous workforce. An **indigenous workforce** will provide connection, trust rapport and re-empower patients in their health journeys. Peer navigation is also important in connecting indigenous patients.

Engagement with Aboriginal and Torres Strait Islander patients and families is achievable when health care workers learn and follow on Country protocols, communicate face to face, and involve communities in co-design of care. This achieves buy-in at ground level and acceptance in communities.

Consultation – importance of education, dialogue and collaboration in co-design. Importance of diversity in engagement. Learn from cultural experts and acknowledge your differences and perspectives.

An important aspect of improving engagement with First Nations patients is realising we are “dealing with history’s mistakes”.

“Success is patients experiencing the same standard regardless of who they talk to”.

First Nations kidney transplants are now at 221. There are increased referrals for transplant assessment and patients are empowered to ask the question – can I have a transplant?

POTENTIAL ACTION POINTS FOR ANZSN

- Advocate for ongoing funding and staffing to make outreach programs business as usual across Australia and New Zealand.
- Advocate to alter transplant allocation algorithms to;
 - Account for groups experiencing disadvantage
 - Extend age-based priority beyond 18 years of age
 - Include pre-emptive listing on deceased donor list to be offered to Aboriginal and Torres Strait Islander Peoples
 - Address state-based differences
- Advocate expansion of and promote benefits of “one day work-ups”



USING DATA TO DRIVE IMPROVEMENT



Chairs: **Professor Nigel Toussaint, A/Professor Nicholas Gray**

Professor Rachael Morton - SWIFT – PROMS/PREMS

Dr Drew Henderson - Quality outliers – Closing the Loop

Dr Adam Steinberg - Quality Indicators – Understanding the Variation

Professor Stephen McDonald - ANZDATA Update

SWIFT – PROMS/PREMS

Symptom monitoring **with feedback Trial** –

SWIFT aims to recruit up to 2400 patients from 143 satellite dialysis units across Australia and New Zealand

The project's hypotheses are;

1) symptom monitoring using IPOS-Renal with feedback to clinicians and patients improves health related quality of life

2) Electronic capture of PROMS within a clinical quality register is cost-effective
Opportunities and challenges from the project include



Patient centeredness – ensuring that it is asking questions that patients care about.
Participant consent – finger sign like parcel delivery.

CALD participation – Translated in 8 different languages, although these are only used 2% of the time.

Representativeness – Currently only 10% First Nations vs 17% in ANZDATA (not yet in NT, 33% LSES, vs 25% in ANZDATA (No private units included yet).

Patient level PROMS feedback - this is a complex and time-consuming process of providing feedback to clinicians and units.

Trends over time – graphing trends is most informative for clinicians.

Patient reported not proxy reported - 70% of patients need assistance completing first survey. Staff training is required to ensure patient reported and not proxy reported outcomes are captured.

Kidney team engagement – needs champions in units who are IT savvy and interested in quality improvement.

Data linkage – initiatives underway where ANDATA is able to link with hospital and Medicare records – this hasn't happened yet.

PREMS – I have all the information I need consistently rated lower than other questions.

A successful PROMS/PREMS program should:

- Focus on issues important to patients
- Raise clinician awareness
- Build rapport and trust
- Support shared decision making
- Promote patient activation and healthy behaviours

Quality Outliers – Closing the Loop

In ANZDATA reports, data from New Zealand has traditionally been adjusted for mortality. Removal of this adjustment indicates that kidney patients in New Zealand have a higher mortality rate than those in Australia. There is also variation between units in New Zealand with some units having significantly higher SMR's than other units. What drives this variation?

ANZDATA has not included ethnicity in the multivariate analysis for SMR but when looked at this does not account for the variation between units. ANZDATA doesn't look at modality mix either as this is a center factor which is modifiable. Looking at the units with the highest SMR's in New Zealand these are also the units with the highest rates of home haemodialysis and peritoneal dialysis. Looking at mortality rates in NZ there is a slightly higher mortality for PD compared with HDD and in-centre HD. Adjusting the SMR model to include a high prevalence of PD (>30% of dialysis patients) as a variable in the SMR model accounts for the variation in outcome between NZ units and also between NZ and Australia.

PD rates are influenced by ethos and capacity constraints of haemodialysis facilities. Selection of patients, patient choice and length of time spent on PD may also influence outcomes. This analysis demonstrates the ability for heads of units to work with ANZDATA to identify and address the underlying causes of variation.

Quality Indicators – Understanding the Variation

One of the Quality Indicators collected by ANZDATA is transplant waitlisting, which is defined by the number of patients aged < 65 years who have been transplanted or wait-listed within 6 months of starting kidney replacement therapy. Analysis of data around this indicator aimed to use unit characteristics and patient characteristics to identify possible reasons for transplant waitlisting variation. Limitations of the analysis included that only patients under 65 were included and paediatric patients were excluded. It is also important to note that waitlisting is a process measure not an outcome measure, with kidney transplantation itself being the ultimate measurable goal.

Multivariate analysis indicates patient level characteristics including SES, First Nations, smoking, vascular disease and diabetes impact waitlisting whereas centre level characteristics such as staff make-up identified during univariate analysis were no longer statistically significant.

Late referral remains a concern and has a significant impact on dialysis vascular access at commencement of dialysis and is also linked to lower rates of transplantation.

ANZDATA Update

Why report – ultimately to achieve better outcomes and better value in kidney care

To Whom – variety of stakeholders
What – individual hospital reports, quality indicator reports

What's new – Dialysis Quality Indicator program, 3 level unit classifications, dialysis capacity survey

Context – What is the impact on consumers? What is the best way to present data? What do administrators understand?

Consumer project – Consumers feel disempowered by reporting because regardless of whether the data for a particular treating unit is good or bad, they have no control over which hospital or unit they are treated at. Overall consumers trust and support public reporting, despite this apparent disempowerment.

Future activities – data linkage rather than collecting exponentially more data is the future of ANZDATA activities – there is a vision to become a data warehouse that allows linkage at a national, jurisdictional, regional and community level.

ANZDATA aims to use traditional clinical Quality Indicators in combination with new markers such as hospital admissions to drive better identification of comorbidities. Comorbidity can be a sliding scale of severity therefore a yes/no answer may not be appropriate. Alternatives could be frequency or length of hospital admissions. We don't yet fully understand the views of consumers and stakeholders, the best formats for report and how effective our efforts are.

Currently, outlier units are sent a letter by ANZDATA indicating that they are an outlier. Hospitals are invited to contact ANZDATA to investigate the reasons. Explanations for outlier status may be due to a simple reason such as failure to report comorbidities. ANZDATA are happy to work through issues to identify statistical or clinical practice reasons for outlier status.

POTENTIAL ACTION POINTS FOR ANZSN

- Annual collection of dialysis capacity data
- Continue to explore options for collection of vascular access bloodstream infections as a clinical quality indicator
- Develop an action plan for units to follow in the event of outlier performance

WORKFORCE AND TRAINING UPDATE

Chairs: **Dr Surjit Tarafdar, Dr Samantha Ng**

A/Professor **Rob Macginley** -
Nephrology Curriculum and Advanced
Training Update

Dr **Melanie Wyld** - Workforce Gender
equity

Dr **Samantha Ng** - Young ANZSN

A/Professor **Bobby Chacko** -
Coordination of Advanced Nephrology
Training – NSW Experience

Professor **David Johnson** -
Coordination of Advanced Nephrology
Training – ANZ Perspective

Nephrology Curriculum and Advanced Training Update

The new nephrology curriculum is now complete. The RACP now offers over 100 online teaching programs in addition to new support for supervisors and a new teaching, learning and assessment (LTA) program.

The Basic Physician Training Program is now a competency-based model – this is based on entrustable professional activities. It includes 72 captures which must be completed and recorded. Progressions through the program are decided by a central committee rather than individual supervisors or hospitals.

The Advanced Training program aims to include;

- A common LTA structure - 72 assessments over 3 years
- A research project
- 25 individual learning goals
- New state-based progression and assessment committee
- Network system
- An exit exam and clinical reasoning OSCE is being considered.



Workforce Gender Equality

Females make up more than 50% of medical graduates and have done for over 30 years with similar numbers in nephrology training. Females make up over 50% of Young Investigator Award recipients and Jacquot research entry awardees. However, there is a loss of women in leadership positions as careers progress. There is lots of support and mentoring at junior level however this dissipates as women compete for funding and resources known as the 'Jennifer effect.'

There have however been improvements in female representation in ANZSN council, committees, creation of EDI committee and a childcare subsidy for ASM. Gender equity and the biases that contribute to it are something that continually need to be worked on to address the gap in leadership, funding and promotion at the senior level. Females in nephrology not only need mentoring (encouragement) but also sponsorship (having their name put forward when they are not in the room).

yANZSN

The focus of yANZSN is to support and empower young kidney professionals. This includes trainees, scientists, and other junior members of the kidney care community.

Achievements of yANZSN to date include;

- Submission on new curriculum
- Trainee weekend
- State-based networking nights
- Invitation to speak at DNT

Challenges for yANZSN include how to count young ANZSN members, and how representative of all young ANZSN members they are. There is lack of understanding among young ANZSN members about purpose or processes of DNT. It is not well understood that all ANZSN members are invited to DNT.

Co-ordination of advanced training in NSW

The old system involved up to 7 job applications with an interview panel of up to 15 people which had to be repeated again before year 3 with trainees required to do a transplant rotation to complete their training. This was very stressful for applicants and time consuming and resource intensive for interview panels and hospitals.

The new network system has three networks, 1 advertisement and interview process, at the commencement of training, with a 7 person interview panel and a guaranteed 3 year contract.

Trainees are able to nominate preferred location within the network with the ability for maternity leave and part time work.

Co-ordination of Advanced Nephrology Training – ANZSN Perspective

ANZSN supports and has advocated for national co-ordination of Advanced Nephrology Training. QLD will move to a network system in 2024. All other jurisdictions have also agreed to aim to move to the network program in the next few years which will include;

- A National jobs dashboard
- Synchronised selection across states
- Workforce supply demand matching
- Transparent selection process
- Co-ordinated networks – guaranteed 3 years training including transplant term

FROM EVIDENCE TO ACTION

Chairs: A/Professor **Andrea Viecelli**,
Terry Jennings, **Professor Rob Walker**

A/Professor **Rathika Krishnasamy** –
CARI Guidelines Updates: New
Developments and Challenges

A/Professor **Simon Jiang** – Kidney
Research Alliance

A/Professor **Katherine Barraclough**
and Dr Jane Waugh – ANZSN ESD
Guidelines

CARI

Is there still a role for guidelines in a world where evidence is changing at a rapid pace and technology such as ChatGPT exists?

How do we keep up with evidence?
The currency of a guideline is about 60 months. Generating new guidelines requires a lot of work and is a slow process.

A solution to these challenges are living guidelines – these are guidelines that update recommendations expeditiously and continually while maintaining the methodological rigor of guidelines.

CARI has developed a timeline for rapid development of living CARI Guidelines in which we are able to produce a guideline within 45 days. This involves support from the CARI office in gathering evidence and an expert working group that reviews and provides specialist advice.

The current CARI workplan involves living guidelines, focused guidelines, traditional guidelines and consumer guidelines.

To select and prioritise guideline topics, CARI has mapped the currency of existing guidelines to identify these that require updating and have produced a ranked list of priority guidelines. These are curated to ensure that they do not overlap with international and existing guidelines and that they address issues specific to Australian and New Zealand patients.

For CARI to remain sustainable there needs to be a methodological approach to funding requests. Current funding is project based and relies on in kind support from the kidney community.

Dissemination of CARI guidelines requires an effective social media strategy including; clear division of information for consumers and health professionals, good infographics and search engine optimisation.

Kidney Research Alliance

The Kidney Research Alliance (KRA) is a collaboration between KHA and ANZSN formed approximately 18 months ago. Research funding for kidney disease is underrepresented compared to other diseases, despite our research publication rates from the ANZ kidney research community being on par or overrepresented internationally.

The clearly identified primary goal of KRA is to lobby for an MRFF Kidney Mission. The secondary goals have not yet been clearly articulated but include support for kidney research in Australia, advocacy for kidney research, and fostering of research collaborations.

Priory setting workshops in 2022 identified key priorities for kidney research in Australia:

- Prevention and detection of kidney injury and kidney disease
- Diversifying kidney treatment
- Equity of access
- Improving patient experience, outcomes and care
- Research transplantation and implementation

Environmental Sustainability Committe

ANZSN aims to have net zero carbon emissions from organisational activities by 2030.

Healthcare is a major contributor to climate change and treatment of kidney disease is one of the most energy resource intensive areas of health.

ANZSN commissioned development of environmental sustainable design guidelines for dialysis units. These guidelines provide;

- Information for decision makers in design and construction of dialysis facilities
- No cost measures able to be implemented by dialysis facilities

Resource reduction initiatives that can be easily undertaken in dialysis facilities include;

- Installing meters to measure water and energy usage of RO systems and HD machines
- Optimising RO and disinfection run times. RO and disinfection times set by default are often much greater than required.

ESC work this year

- We know this is not routinely taught and not intuitive for many
- Can be hard for clinical staff to 'dive in'

ESC aims...

- focus in these 5 dialysis-specific initiatives
- develop simple 'how to' guides & case studies
- support implementation in units.



OPTIMAL KIDNEY HEALTH FOR ALL

Chairs: **Dr Drew Henderson, Dr Kelly Lambert**

Professor **Ann Bonner** - Nurse led CKD Management Programs

Dr **Ruth Large** (virtual) - Telehealth

Dr **Adam Mullan, Dr Drew Henderson** - Managing aggressive patients – case vignette and debate

A/Professor **Dominique Martin** (virtual) - Ethical challenges

Nurse-Led CKD Management Programs

Nurse-led programs usually involve an allocated patient case load and primary responsibility, usually around education, support and monitoring. Nurse-led models are common in kidney care.

Nurse-led models result in high levels of patient satisfaction and positive impact on outcomes. These can reduce waiting times, inpatient visits, length of stay and nephrologist workloads.

Nursing specialisations include clinical nurse, clinical nurse consultant, nurse practitioners, and nurse navigators.

Advanced practice nurses work autonomously within the scope of practice or a registered nurse as part of health team whereas nurse practitioners work autonomously as part of a health team with independent and collaborative decision making about patient care. Nurse Practitioners have an extended scope of practice and require a Masters Degree approved by AHPRA.

Telehealth

Telehealth is the use of digital technology to provide healthcare where the recipient and provider are separated by time or distance.

History of telehealth extends from the wind-up radio in Australia to the first 24-hour help line – the Plunket line in New Zealand. Providers offering telehealth expanded exponentially in the 2000's. Telehealth use in nephrology augments face to face consults but does not replace it or make up for staff shortages.

Guidance from AHPRA is that telehealth must supply a similar level of care as in person. As such records need to be kept. Any text conversations or emails should be captured and recorded.

Ethical challenges include evidence that many patients in remote areas do not have access to quality internet services. Others may not be able to afford internet plans that support digital health platforms. Things to consider include; data coding, appropriate technology, clinical support, patient selection, skillsets required, training, keeping safe.

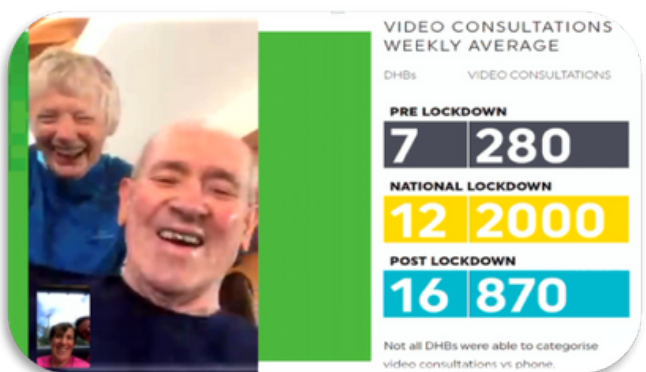
Managing aggressive patients – case vignette and debate

The speakers shared experiences of challenging patients with the assistance of a medical ethicist. An ethical dilemma exists where patients may be violent, aggressive and non-compliant but still require ongoing, lifesaving dialysis. The examples provided raised many questions including;

- How do nephrology units balance the duty of care to treat these patients with the duty of care to staff, other patients and the general public?
- What is the role of other services such as social services, mental health and security?
- How do we ensure culturally appropriate care in challenging circumstances?
- How to deal with alcohol and other substance abuse in people with kidney disease?
- Who is responsible for addressing these issues?

LIVING WITH KIDNEY DISEASE

PQC consumer representative Martine Allars produced a series of videos on patients with kidney disease outlining their story, their challenges and hopes for the future. We sincerely thank Martine and the participants for bravely sharing their stories and reminding us of the lifesaving and changing care that the kidney community provide and our obligation to ensure each individual is provided with the best care possible.



CONCLUSION

The 2023 DNT workshop on the lands of the Gubbi Gubbi people in Noosa was an exciting opportunity for the nephrology community to meet to discuss critical issues of policy and quality, in the first face to face DNT workshop since the pandemic. The theme of “Optimal and Equitable Kidney Health for All” built on the work of the Society from 2022, highlighted by the release of the ANZSN Indigenous Statement and the ANZSN Equity in Kidney Care Position Statement.

The meeting opened with a thought-provoking overview of key equity challenges for kidney care facing ANZSN. Important insights were shared into challenges around equity of kidney transplant care for Indigenous people, both from the Australian and Aotearoa New Zealand perspectives. This session addressed equity challenges related to multiple factors including rural and remote challenges, culturally and linguistically diverse communities, and gender. The opening day of DNT 2023 also emphasised the importance of consumer engagement in kidney care. Polling revealed strong ongoing support from DNT attendees for a role for patient reported measures in nephrology.

The presentation to open day 2 DNT2023 highlighted the current haemodialysis capacity crisis in the Northern Territory, stimulating broader discussion about dialysis capacity challenges seen in many parts of Australia and New Zealand. The important advocacy role for the ANZSN and its leadership in addressing these treatment capacity challenges was emphasised. The session on kidney transplantation identified a range of challenges and opportunities, with an emerging theme of how to address the challenge of maximising opportunities for people kidney with kidney failure to benefit from transplantation, especially people from groups who have historically been disadvantaged.

In the “Using Data to Drive Improvement” session, a highlight was a presentation demonstrating a real-world example of how actioning quality indicator outlier outcomes can be used as a stimulus to advocate for improved care and services. The session on Workforce and Training Update generated in depth and lengthy discussions, especially about the vital role for ANZSN in nephrology Advanced Training, confirming the passion that ANZSN members have for this topic.

The final day of the workshop had numerous highlights including presentations on CARI guidelines, the Kidney Research Alliance, telehealth, nurse led CKD care, ethical challenges, and a very practical presentation from the ESC about strategies to minimise energy and water waste in dialysis units.

I would like to thank and acknowledge the many people who contributed to the success of the 2023 DNT workshop including all the session chairs and presenters. A big thank you to our 2023 DNT local organising committee A/Prof Andrea Viecegli and Dr Dev Jegatheesan, who worked tirelessly in the organisation of this meeting. Thanks also to the ANZSN team, especially our Policy Officer Ms Joanna Tsang, the Conference Design team, and our industry sponsors. Finally, thank you to all the ANZSN members who attended the DNT and contributed to the energy, enthusiasm and passion that is vital to the purpose of the DNT Workshop. I hope that like me, people came away from the workshop optimistic for the role of our Society and its progress in its vision for optimal kidney health for all people.

A/Professor Peter Mount

Chair, ANZSN Policy and Quality Committee

DNT POLLING QUESTION SUMMARY

SESSION ONE: EQUITY CHALLENGES IN KIDNEY CARE

	Question/Answer Options	Percentage (largest to smallest)
1.1	“Cultural Safety” in healthcare is best defined as:	
	Ensuring you have the knowledge and skills to deal with people of different cultures	41
	Providing patients with the power to comment on the health care they receive, and that the care meets their cultural needs	40
	A critical consciousness into the biases which affect health care	13
	Having clinical spaces which reflect indigenous cultures	6
1.2	“Health Equity” is best defined as:	
	Recognising that different levels of advantage require different approaches and resources	61
	The absence of avoidable difference in health	19
	Treating all people equally	18
	Giving more resources to certain people based on their ethnicity or gender	2

SESSION TWO: CONSUMER ENGAGEMENT TO OPTIMISE KIDNEY HEALTH

	Question/Answer Options	Percentage (largest to smallest)
2.1	Q1 - At the last DNT meeting in August 2021, 81% of respondents agreed that PREMs/PROMs would significantly improve the lives of people with kidney disease. Working Groups have been established, but it is unclear when they will be finalising the PREMs/PROMs. How quickly should we aim to have PREMs and PROMs in place?	
	1-2 years from now	73
	2-3 years from now	24
	3-5 years from now	3
2.1.1	Q1 - In your unit, which key barrier identified in the published research is the most significant issue that patients face:	
	financial considerations?	43
	access to care?	32
	Providing information and knowledge? or	25
2.2	Q1 - What do you think is the biggest barrier in terms of patients having the capability to better manage their condition?	
	Competing life priorities	47
	Poor health literacy	30
	Lack of knowledge	11
	Pain and fatigue	11
	Low mood affecting memory	2

2.3	Q2 - What would be the first area you would focus on to support people starting dialysis?	
	A) Detailed information and support on understanding their treatment	39
	B) Diet and wellbeing resources and support	17
	C) Peer support/counselling	22
	D) Information on navigating the health system	22
2.4	Q3 - What would be the key barrier for you in referring your patients into the KH4L program?	
	C) Time to select and refer appropriate patients	44
	E) Lack of information on program content/outcomes	36
	A) Integrating patient learnings into ongoing care	11
	B) Perceived value of program in positively impacting patient outcomes	5
	D) KHA as credible program provider	5
2.6	Q1 - Please tell us currently which level of consumer engagement your renal unit has.	
	c) Consult	35
	d) Involve	20
	b) Inform	18
	a) None	13
	e) Collaborate	11
	f) Empower	4
2.7	Please tell us which level of consumer engagement you want to achieve for your unit.	
	d) Collaborate	41
	e) Empower	39
	c) Involve	18
	a) Inform	2
2.8	Q3 - What could the ANZSN do to support you to make the shift in consumer engagement that you seek?	
	c) Partner with local and/or national patient groups to provide shift the level of consumer engagement?	63
	a) The development of best practice solutions?	22
	b) More detailed sessions at future conferences around alternative consumer engagement models?	15

SESSION THREE: INNOVATION AND IMPROVEMENT IN DIALYSIS

3.1	Q1 Do you have any haemodialysis capacity issues in your unit?	
	Yes	85
	No	15
3.2	Q2 Have you ever had to cancel or defer a patient's haemodialysis treatment due to lack of capacity?	
	Yes	69
	No	31
3.3	Q3 In your unit, how is urgent start PD offered presently?	
	Inconsistent, but is available if requested	53
	We can't offer due to a lack of infrastructure	34
	Not applicable – PD is not offered in our unit	7
	This is offered widespread instead of CVC-facilitated HD	6
	Other (enter free text)	1
3.4	Q4 Is there a place for formalised assisted PD in Australia and New Zealand (like in Canada)?	
	Yes	80
	No	9
	I don't know	8
	Other (enter free text)	3
	assisted of very feasible if automated pad main modality as only need health worker twice per day	
	we do some urgent start if vascular access is an issue we do nursing home pd and utilise frequently	
3.5	Q9 Do your patients provide written informed consent prior to commencing dialysis?	
	Yes	62
	No	38

3.6	Q8 What should be the next trial in the vascular access space?	
	Angioplasty versus revision of AVF	25
	Rewiring catheters versus replacing catheters in setting of infection	22
	Catheter versus fistula	15
	Management of catheter related blood stream infections	15
3.8	Q7 Why have trials in the vascular access space not worked? (select all that apply)	
	Health system factors	38
	Patient factors	31
	Physician factors	15
	We already have the answer	15
	its not important	0
3.8	Q6 - If you start a patient on incremental or twice weekly dialysis, how long are they on this before increasing to three times per week?	
	3-6 months	43
	6-12 months	30
	0-3 months	14
	12-24 months	9
	>24 months	4
3.9	Q5 - How likely are you to start people on incremental or twice weekly dialysis?	
	Neutral (Sometimes)	35
	Likely (Often)	27
	Unlikely (Occasional)	19
	Very unlikely (Never)	13
	Very likely (Always)	6

3.10	Q3 In your unit, how is urgent start PD offered presently?	
	Inconsistent, but is available if requested	53
	We can't offer due to a lack of infrastructure	34
	Not applicable – PD is not offered in our unit	7
	This is offered widespread instead of CVC-facilitated HD	6
3.11	Q1 Pre Debate - Are catheters really that bad?	
	No	59
	Yes	41
3.12	Q3 Was this debate topic useful?	
	Yes	91
	No	9
3.13	Q4 Are Sradha and Kevan awesome?	
	yes	100
3.14	Q2 Post Debate - Are catheters really that bad?	
	No	63
	Yes	37

SESSION FOUR: OVERCOMING INEQUITIES IN TRANSPLANTATION

4.1	Q1 Where do you most often advise your patients to look for kidney transplant information (select one answer only)?	
	KHA/ KHNZ	93
	Transplant Australia	5
	TSANZ	2
4.2	Q2 Apart from developing a guidance document and providing a list of reference materials, what else would you like the Transplant Education WG to achieve (select one answer only)?	
	Develop consumer-friendly information on high KDPI & HCV NAT positive donor kidneys (with TSANZ/KHA/KHNZ)	74
	Help coordinate links on ANZSN/TSANZ webpages to existing KHA/KHNZ resources	15
	Pursue a unified consent form that ANZSN/TSANZ will endorse and all jurisdictions will adopt	5
	Nothing else – they have achieved the set goals	3
	Something else – please specify in the Discussion Forum	2
4.3	Q3 Should we create a dashboard to personalize expected waiting list experience and expected time waiting based on individuals characteristics? (age, sex, blood group, cPRA, race, state of residence etc)	
	Yes	95
	No	5
4.4	Q4 Given we already prioritise some disadvantaged groups in the allocation algorithm (kids, highly sensitized), and we have evidence that there are other groups experiencing significant disadvantage on the wait list (Aboriginal, women), should we also account for this in allocation?	
	Yes	81
	No	19
4.5	Q5 The elephant in the room is the state-based difference, which does not deliver equitable access to a kidney transplant for all Australians. Do we agree to act to address this? (this may mean more shipping of kidneys, or other adjustments to the national override)?	
	Yes	84
	No	16

4.6	Q6 As is the case in NZ, should Australian living kidney donors who subsequently develop ESKD be provided with state based prioritisation for deceased donor listing, with state TAC review and RTAC oversight?	
	Yes	66
	. Maybe	22
	No	12
4.7	Q7 Should we consider giving more priority to people who have a lower survival on the waitlist (age/demographics/comorbidity) but stand to benefit from transplantation.	
	Maybe	49
	No	28
	Yes	23
4.8	Q8 If a graft is lost early post-transplant, patients can usually retain their prior waiting time (with appropriate case review/oversight). This is true for graft loss within:	
	12 months	33
	3 months	32
	6 months	20
	1 month	15
4.9	Q9 Should the concept of "paediatric" priority be extended, in a graded fashion to include people	
	Up to the age of 21	33
	Up to the age of 25	28
	Or not, leave unchanged 0-18 years	20
	Up to the age of 35	20
4.10	Q10 Should the concept of "paediatric" priority be extended, in a graded fashion to increase the prioritisation of younger children over adolescents	
	No	38
	Maybe	34
	Yes	29
4.11	Q11 Should pre-emptive listing on the deceased donor list be offered to Aboriginal and/or Torres Strait Islander patients to improve access to Transplantation?	
	Yes	71
	No	29

4.12	Q12 In the Health decision making processes for Aboriginal and / or Torres Strait Islander patients, do you believe there to be elements of Institutional Racism currently at play in your Health Service?	
	Yes	63
	No	37
4.13	Q13 In your unit/renal centre, what is currently the most significant barrier to timely listing for transplant (select one)	
	Availability of tests which required waiting listing/grading	32
	Lack of engagement from patients with work up process	26
	Waiting times for transplant nephrologist review	19
	Lack of transplant coordinator	12
	Lack of referral to initiate transplant workup	8
	Transport barriers	3
4.14	Q14 In your unit/renal centre, do you have a structure pathway to facilitate timely transplant investigations	
	Yes	53
	No	45
	Don't know	3
4.15	Q15 In your unit/renal centre, do you believe you are currently able to/resourced to roll out a similar 'one day' workup model	
	No	75
	Yes	17
	Don't Know	8

SESSION FIVE: USING DATA TO DRIVE IMPROVEMENT

5.1	Q1 Does your renal unit routinely use a patient reported experience measure (PREM) for dialysis and transplant patients?	
	No	58
	Yes	32
	Unsure	9.0
5.2	Q2 If yes, what tool do you mainly use Hospital-wide satisfaction/experience survey	
	State health department outpatient PREM	41
	Bespoke kidney specific survey	27
	Blank	14
	Other	12
	Modified validated kidney PREM	6
5.3	Q3 If resources were available would you submit PREMs to ANZDATA	
	Opt in annually	76
	Opt in as a once off	12
	other	8
	No	4
5.4	Q1 Have you (or your Unit) ever been asked about ANZDATA Individual Hospital or Quality Indicator Reports by your hospital Executive or Safety and Quality Committee?	
	Don't know	28
	No	36
	Yes	37
5.5	Q2 Should ANZSN become involved in supporting Units that have outlier results?	
	Yes	72
	Unsure	18
	No	10

5.5	Q3 If ANZSN was to become involved in supporting Units that have outlier results, what might that involve?	
	All of the above	61
	Assistance with review	21
	Identifying experts who are able to assist	8
	Advocacy	5
	Other	4
	Identifying exemplar units	1
5.6	Q4 ANZDATA could have a one off data point annually. This would collect a single result but not every year, and may expand our knowledge and needs of the population. Examples may be a simple frailty index, simple cognitive assessment, PREMs, etc. - Would you support this?	
	Yes	73
	Unsure	22
	No	5
5.8	Q5 ANZDATA could have a one off data point annually. This would collect a single result but not every year, and may expand our knowledge and needs of the population. Examples may be a simple frailty index, simple cognitive assessment, PREMs, etc. - Would this be feasible?	
	Unsure	44
	Yes	41
	No	15
5.9	Q6 Should dialysis capacity be an annual audit?	
	Yes	84
	Unsure	14
	No	3
5.10	Q7 Who sees Individual Hospital Reports and Quality Indicator Reports in your Unit?	
	Only some staff	61
	All staff	38
	Hospital Safety and Quality Committee	1
5.11	Q8 Would it be feasible to enter data on vascular access bloodstream infections?	
	Yes	75
	Unsure	17
	No	8

5.12	Q9 Do you use electronic medical records for clinical notes?	
	Yes but data cannot be exported	55
	No	26
	Yes and data can be exported	17
	Unsure/other	1

SESSION SIX: WORKFORCE AND TRAINING UPDATE

6.1	Q1 Three-year length of contract for Nephrology advanced training	
	Strongly approve	69
	Approve	27
	Disapprove	3
	Neither approve nor disapprove	1
6.2	Q1a. Do you agree we shall progress and develop a Clinical reasoning exam?	
	Yes	79
	No	21
6.3	Q2 Would accept the network model in your state if introduced	
	Definitely would	81
	Probably would	15
	Probably would not	3
	Definitely would not	1
6.4	Q2a. Will you be able to support the flexible training as part of the state based Selection and progression committee	
	Yes	72
	No	28

6.5	Q3 What is your view about the current number of advanced nephrology training positions available in ANZ?	
	There is about the right number	47
	There are somewhat too many	27
	There are somewhat too few	14
	There are way too many	11
6.6	Q4 What is your view about the current number of fellow positions available in ANZ?	
	There are somewhat too few	53
	There is about the right number	21
	There are way too few	16
	There are somewhat too many	7
	There are way too many	4
6.7	Q5 Do you support network/run-through training?	
	Yes	100
6.8	Q3 Do you believe there are currently gender equity in the nephrology workforce	
	Yes minor (I identify as male)	26
	Yes substantial (I identify as female)	23
	Yes substantial (I identify as male)	21
	Yes minor (I identify as female)	14
	No (I identify as male)	11
6.9	Q4 My workplace has a highly effective approach to ensuring there is equality between women and men	
	Neither agree nor disagree	38
	Agree	28
	Disagree	17
	Strongly agree	13
	Strongly disagree	4

6.10	Q5 Given the progress made since the last workforce survey, what workforce issues or objectives do you think the ANZSN should explore? (Select all that apply)	
	Benchmarking (eg of diversity of invited speakers at conferences)	15
	Career progression	10
	Diverse representation on council, plenary speakers at conferences etc	10
	Flexible consultant working arrangements	14
	Flexible training arrangements	11
	Mentoring	9
	Networking	6
	Research grant applications	11
	Training program selection	9
	Unconscious bias	5
6.11	Q6 Should ANZSN sponsor childcare facilities at its ASM	
	Yes	93
	No	7
6.12	Q7 What would be useful to you in a mentor program? (Select the most beneficial)	
	Training/coaching on building effective best-practice mentorship skills	49
	Structured schedule for mentor-mentee meetings	42
	In person meet-ups at ANZSN ASM	9

SESSION SEVEN: FROM EVIDENCE TO ACTION

7.1	Q1 Do you see Kidney Research Alliance performing any other functions apart from advocating for an MRFF mission?	
	yes	58
	no	27
	If yes, think about potential activities that KRA could undertake.	16
	Free text answer – Research register	
7.2	Q2 What is your perspective on industry involvement with the KRA?	
	Subscription based model- pay to participate but no voting rights.	69
	Industry can consult but no paid contribution and no voting rights.	14
	I am against industry involvement in the KRA.	13
	Subscription based model- pay to participate directly.	5
7.3	Q1 What do you see as the main barriers to implementation of ANZSN's Environmentally Sustainable Design Guidelines in your unit? (Please tick all that apply)	
	Lack of influence over the ultimate decision makers for capital works	35
	Interested people, but no time	27
	No obvious 'champions' to drive implementation	17
	Lack of understanding of guideline content	11
	Added capital costs that may be incurred	10
7.4	Q2 Which of the following would be most useful to your unit?	
	.Step by step guides for high impact and/or low-cost initiatives	72
	Mentoring provided to green champions	11
	Environmental Sustainability Committee advocacy to decision makers	9
	Training webinars for green champions	7
7.5	Q3 Would you have the capacity to allocate protected time to a green champion in your unit to work on environmental initiatives?	
	No	51
	Yes	49

7.6	Q1 In the era of rapidly evolving evidence and growing platforms such as UpToDate and ChatGPT, is there still a role for CARI Guidelines (select all options that apply)?	
	Yes, it provides up to-date rigorous assessment of benefits and harms of care options	34
	Yes, it is a reliable decision-making tool	23
	No, there is not much use for guidelines anymore	21
	Yes, it is clinically useful but not easily accessible	21
7.7	Q2 How to improve implementation and translation of the CARI Guidelines (select all options that apply)?	
	CARI Guidelines need to be more accessible e.g. using mobile phone apps	42
	Improve CARI's website and Social Media profile	23
	Pilot Implementation projects in clinical setting	13
	Set Quality Indicator benchmarks following the release of the guidelines	12
	Society may provide more support for clinical guidelines pathway	9
7.8	Q3 Following review of the goals and timeline for living guidelines, are you likely to volunteer to be part of a CARI living guidelines working group (select most appropriate option)?	
	Likely to volunteer	45
	Unlikely to volunteer as I am time poor	32
	Unlikely to volunteer as I don't understand the workload of living guidelines	12
7.9	Q4 The current funding model for CARI guidelines has challenges in terms of sustainability. Would you accept industry support (if the appropriate governance is in place) for CARI?	
	Yes	76
	No	24

SESSION EIGHT: OPTIMAL KIDNEY HEALTH FOR ALL

8.1	Q1 I am working in a renal service which has an identified nurse-led service/model/clinic:	
	Yes	76
	No	24
8.2	Q2 In Australia, the first nurse practitioners were endorsed by Ahpra in	
	2000	45
	2010	41
	1990	11
	2020	2
8.3	Q3 I feel competent reviewing patients by video	
	Yes	44
	Mostly	41
	No	15
8.4	Q4 I would like to use video consultation more in my practice	
	Yes	47.5
	Maybe	45
	No	7.5
8.5	Q2 I currently "see" patients by video or phone in my practice	
	By video as much as I am able	45
	Occasionally when the patient/someone else specifically asks me to	35
	By phone only	20
8.9	Q1 Does your service face issues similar to those as described in the 2 cases?	
	Yes	89
	No	11

8.10	Q3 Has your service experienced violence against workers?	
	yes	100
8.11	Q2 Does your service have policy re violence against health care workers?	
	yes	94
	no	6
8.12	Q4 Does your service have a formal policy on management of challenging patients?	
	No	61
	Yes	39
8.13	Q5 Who takes the lead role in managing challenging patients in your unit?	
	Lead Consultant	52
	Head of Unit	35
	Charge Nurse Manager	6
	Hospital Legal Team	3
	N/A	3
8.14	Q6 Do you think it would be useful for the ANZSN to develop a position statement on the rights and responsibilities of renal patients (document to include a best practise statement, legal opinion and staff resources required to gain the best outcome for these patient)	
	Yes	72
	No	28