Complete Summary

GUIDELINE TITLE

Guidance on home compared with hospital haemodialysis for patients with end-stage renal failure.

BIBLIOGRAPHIC SOURCE(S)

National Institute for Clinical Excellence (NICE). Guidance on home compared with hospital haemodialysis for patients with end-stage renal failure. London (UK): National Institute for Clinical Excellence (NICE); 2002 Sep. 20 p. (Technology appraisal guidance; no. 48).

GUIDELINE STATUS

This is the current release of the guideline.

August 2005: "Having re-run the search strategy from the original assessment report the Institute found no relevant additions to the evidence base that would have a material effect on the guidance. Consequently NICE proposed that the original guidance become static. In October 2005, a decision was made to make it a static guideline. See Review Proposal and Review Decision available at the National Institute for Health and Clinical Excellence (NICE) Web site.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

End-stage renal failure (ESRF)

GUIDELINE CATEGORY

Assessment of Therapeutic Effectiveness
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nephrology

INTENDED USERS

Advanced Practice Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To assess whether home haemodialysis is more effective and cost-effective than haemodialysis carried out in a hospital or a satellite unit, for people with end stage renal failure, except those for whom peritoneal dialysis is currently adequate

TARGET POPULATION

Patients with end-stage renal failure who, after detailed assessment of all their treatment options, have been defined as being suitable for haemodialysis

INTERVENTIONS AND PRACTICES CONSIDERED

1. Home haemodialysis
2. Haemodialysis in a hospital/satellite unit

MAJOR OUTCOMES CONSIDERED

- Clinical effectiveness
    - Quality of life
    - Hospitalisation rate
    - Employment/school status
    - Technique failure
    - Access failure
    - Measures of anaemia
    - Erythropoietin use
    - Biochemical indices of renal disease
    - Dialysis adequacy
    - Blood pressure
    - Complications, including intradialytic complications
    - Mortality
- Cost effectiveness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by the Health Services Research Unit; the Health Economics Research Unit, Institute of Applied Health Sciences; Department of Medicine and Therapeutics, University of Aberdeen (See the "Availability of Companion Documents" field.)

Clinical Effectiveness

Search Strategy

Electronic searches were conducted to identify published and unpublished studies on the clinical and cost-effectiveness of haemodialysis carried out at home compared with haemodialysis carried out in a hospital or satellite unit, for people with end-stage renal failure (ESRF). The search terms were built upon those of a previous health technology assessment review of methods of dialysis, and involved the use of Medical Subject Headings (MeSH) as well as textword searching. The following databases were searched. The full details of each strategy are listed in Appendix 2 of the Assessment Report (see "Availability of Companion Documents" field).

- MEDLINE 1966-5 October 2001, the Excerpta Medica database (EMBASE) 1980-2001 (week 46), HealthSTAR 1975-2000, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) 1982-October 2001. Separate search strategies were developed for each database and then combined to produce a final strategy that was run concurrently on the four databases. Duplicates were removed from the resulting set using Ovid's de-duplicating feature. Running separate searches for each database would have resulted in 3669 hits but the combined search, after de-duplication, resulted in 2949 hits.
- PREMEDLINE (Ovid) 13 December 2001.
- Biosciences Information Service (BIOSIS) (Edina) 1985-October 2001.
- Science Citation Index (Web of Science) 1981-October 2001.
- The Cochrane Library (Issue 3 2001). Within The Cochrane Library, the Cochrane Database of Systematic Reviews (CDSR), Cochrane Controlled Trials Register (CCTR), Database of Abstracts of Reviews of Effectiveness (DARE), NHS Economic Evaluation Database (NHS EED) and Health Technology Assessment Database (HTA) were searched.
- National Research Register (Issue 3 2001).

- Health Management Information Consortium (HCN) 1979-2001.
- British Library Inside (December 2001).
- National Library of Medicine (NLM) Gateway http://gateway.nlm.nih.gov/gw/Cmd (accessed 4 December 2001) was used to search HSRProj, Health Services Research Meetings and Locatorplus.
- Current Controlled Trials http://www.controlled-trials.com/ (accessed on 4 December 2001)
- Clinical Trials http://clinicaltrials.gov/ct/gui/c/r (accessed on 4 December 2001).
- ReFeR–DH Research Findings Register.
- World Wide Web was searched using the Northern Light search engine (accessed on 6 December 2001).
- References of selected studies were checked.
- A Science Citation Index (1981 to January 2002) cited reference search was carried out for all studies selected for inclusion in the review.

Inclusion and Exclusion Criteria

All titles and abstracts identified by the above search strategies were assessed to identify potentially relevant items. For all potentially relevant items, full text papers were then obtained and formally assessed independently by two researchers to check whether they met the inclusion criteria, using a study eligibility form developed for this purpose (see Appendix 3 of the Assessment Report [see "Availability of Companion Documents" field]). Any disagreements that could not be resolved through discussion were referred to an arbiter. The following inclusion criteria were applied:

Types of Study

Randomised controlled trials (RCTs), controlled clinical trials (CCTs), comparative observational studies, or systematic reviews of the above study designs were included. Reviews that did not describe how the studies included in the review were identified and synthesised (i.e., did not contain a methods section) were excluded. Studies where no attempt was made to match or describe the sociodemographic and/or comorbidity of the participant groups were excluded. With regard to observational studies, although initially it was the developer's intention to only include prospective comparative observational studies due to the limited data this condition was subsequently relaxed to also include retrospective comparative observational studies. Studies reported in non-English languages were noted (see Appendix 4 of the Assessment Report [see "Availability of Companion Documents" field]) but not included in the review.

Types of Participants

Participants included people suffering from end stage renal failure, except those for whom peritoneal dialysis was currently adequate. Where data allowed, the patient population was split into four groups: adults by risk class (low, medium, and high risk), and children.

Types of Intervention

For inclusion, intervention comprised haemodialysis carried out at home compared with haemodialysis carried out in a hospital or satellite unit.

Types of Outcomes

Primary outcomes were quality of life, hospitalisation rate, employment/school status, technique failure, and access failure. Other outcomes were measures of anaemia, erythropoietin (EPO) use, biochemical indices of renal disease, dialysis adequacy, blood pressure, complications (including intradialytic complications), and mortality.

Cost Effectiveness

Search Strategies

Studies that reported both costs and outcomes of home versus hospital or satellite haemodialysis were identified from a systematic review of the literature described above. The only additional search performed was on the Harvard Database of cost-utility analyses.

Inclusion and Exclusion Criteria

To be included, studies had to compare home and hospital haemodialysis in terms of costs and effectiveness. Studies reported in languages other than English were identified from their abstracts but were not included in the review. One reviewer assessed all abstracts for relevance. Full papers were obtained for all studies that appeared potentially relevant and were then formally assessed for relevance.

NUMBER OF SOURCE DOCUMENTS

Clinical Effectiveness

In total, 27 published studies met the inclusion criteria on effectiveness. There were four systematic reviews, one randomised crossover trial, and 22 comparative observational studies.

Cost Effectiveness

A total of 18 studies that considered both costs and outcomes were identified from the review of the literature as eligible for inclusion.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): The National Institute for Health and Clinical Excellence (NICE) commissioned an independent academic centre to perform a systematic literature review on the technology considered in this appraisal and prepare an assessment report. The assessment report for this technology appraisal was prepared by: the Health Services Research Unit; the Health Economics Research Unit, Institute of Applied Health Sciences; Department of Medicine and Therapeutics, University of Aberdeen (See the "Companion Documents" field.)

Clinical Effectiveness

Data Extraction Strategy

A data abstraction form was developed purpose (see Appendix 5 of the Assessment Report [see "Availability of Companion Documents" field]) to record details of study designs, characteristics of participants, interventions, and outcomes. The form was based on one used in a systematic review of methods of dialysis therapy. Two reviewers extracted data independently. Any differences that could not be resolved through discussion were referred to an arbiter.

Quality Assessment Strategy

Two reviewers independently assessed the quality of the included studies. Any differences that could not be resolved through discussion were referred to an arbiter. The methodological quality of the systematic reviews was assessed by a previously validated 10-item checklist (see Appendix 6 of the Assessment Report [see "Availability of Companion Documents" field]). The checklist contained nine criteria, scored as "yes," "partially," or "no," depending on the extent to which they had been met. There was also one summary criterion for overall methodological quality, scored on a 1 to 7 scale, where 1 indicates "extensive bias" and 7 indicates "minimal bias."

The primary studies were assessed using a checklist (see Appendix 7 of the Assessment Report [see "Availability of Companion Documents" field]). The checklist was designed to assess the quality of both randomised and non-randomised studies and contained 27 questions in total, covering the following subscales:

- Reporting (ten questions)
- External validity (three questions)
- Internal validity – bias (seven questions)
- Internal validity – confounding (six questions)
- Power (one question)

The checklist allowed an overall score for study quality to be reported, as well as scores for each of the subscales. Question 27 of the checklist (power) was simplified to just check whether the study had provided an indication of statistical power. A list of principal confounders and possible adverse events was developed (see Appendix 8 of the Assessment Report [see "Availability of Companion Documents" field]) to provide supplementary information to questions five and eight of the checklist. The maximum achievable scores within each subscale were: reporting (11), external validity (3), internal validity – bias (7), internal validity – confounding (6), providing an overall maximum achievable score of 27.

Cost Effectiveness

Data Extraction Strategy

The following data were extracted for each included study.

- The study characteristics
    - The research question
    - The study design
    - The comparison
    - The setting (United Kingdom (UK) versus non-UK)
    - Treatment groups
    - Numbers receiving or randomised to each intervention
    - Dates to which data on effectiveness and costs related
    - Other characteristics and follow-up.
    - Duration of follow-up for both effectiveness and costs
- Results
    - Summary of costs, effectiveness and/or utility (point estimate and, if reported, range or standard deviation (sd))
    - Sensitivity analyses (if any)
- Conclusions as reported by the authors of the study

Quality Assessment Strategy

A single economist assessed included studies against the 35 point British Medical Journal (BMJ) checklist for reviewers of economic analyses. The questions were set out on a standard form generated before the review. These criteria can be split into three broad headings: those that relate to design issues (criteria 1 to 7); those that relate to data collection issues (criteria 8 to 19); and those that relate to analysis and interpretation of results (criteria 20 to 35).

Data Synthesis

No attempt was made to synthesise quantitatively the studies that were identified. Data from all included studies published after 1990 were summarised and critiqued by a single economist in order to identify common results, variations and weakness between studies. The data were then interpreted alongside the results of the systematic review of effectiveness so that conclusions could be drawn on the relative efficiency of home versus hospital or satellite haemodialysis.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Considerations

Technology appraisal recommendations are based on a review of clinical and economic evidence.

Technology Appraisal Process

The National Institute for Health and Clinical Excellence (NICE) invites 'consultee' and 'commentator' organisations to take part in the appraisal process. Consultee organisations include national groups representing patients and carers, the bodies representing health professionals, and the manufacturers of the technology under review. Consultees are invited to submit evidence during the appraisal and to comment on the appraisal documents.

Commentator organisations include manufacturers of the products with which the technology is being compared, the National Health Service (NHS) Quality Improvement Scotland and research groups working in the area. They can comment on the evidence and other documents but are not asked to submit evidence themselves.

NICE then commissions an independent academic centre to review published evidence on the technology and prepare an 'assessment report'. Consultees and commentators are invited to comment on the report. The assessment report and the comments on it are then drawn together in a document called the evaluation report.

An independent Appraisal Committee then considers the evaluation report. It holds a meeting where it hears direct, spoken evidence from nominated clinical experts, patients and carers. The Committee uses all the evidence to make its first recommendations, in a document called the 'appraisal consultation document' (ACD). NICE sends all the consultees and commentators a copy of this document and posts it on the NICE website. Further comments are invited from everyone taking part.

When the Committee meets again it considers any comments submitted on the ACD; then it prepares its final recommendations in a document called the 'final appraisal determination' (FAD). This is submitted to NICE for approval.

Consultees have a chance to appeal against the final recommendations in the FAD. If there are no appeals, the final recommendations become the basis of the guidance that NICE issues.

Who is on the Appraisal Committee?

NICE technology appraisal recommendations are prepared by an independent committee. This includes health professionals working in the NHS and people who

are familiar with the issues affecting patients and carers. Although the Appraisal Committee seeks the views of organisations representing health professionals, patients, carers, manufacturers and government, its advice is independent of any vested interests.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The assessment report identified, from a range of countries, 18 studies that considered costs and outcomes. Virtually all the evidence indicated that the annual cost of home dialysis was less than that of hospital dialysis. The reported costs associated with haemodialysis in a satellite unit varied considerably, depending on staffing and the ability to maximise the use of the dialysis equipment. In general, though, satellite haemodialysis was found to cost more than home haemodialysis. Despite initial higher costs of home haemodialysis due to set-up and training, the payback period for these costs had been estimated on average as 14 months; however, this estimate came from the early 1990s, and the exact cost advantage was difficult to determine because of patient selection bias. Most studies found patient survival to be at least equal or better for home haemodialysis compared with hospital dialysis. Lifetime treatment costs for an identical group of patients will be higher for home haemodialysis if the treatment is beneficial and leads to longer survival.

See Section 4.2 of the original guideline document for a detailed discussion of the cost-effectiveness analysis.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Consultee organizations from the following groups were invited to comment on the draft scope, Assessment Report and the Appraisal Consultation Document (ACD) and were provided with the opportunity to appeal against the Final Appraisal Determination.

- Manufacturer/sponsors
- Professional/specialist and patient/carer groups
- Commentator organisations (without the right of appeal)

In addition, individuals selected from clinical expert and patient advocate nominations from the professional/specialist and patient/carer groups were also invited to comment on the ACD.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

This document provides guidance on the location in which haemodialysis is carried out; it does not address the wider issues of frequency of dialysis sessions and how haemodialysis compares with other forms of renal replacement therapy. These recommendations are applicable only to those patients who, after detailed assessment of all their treatment options, have been defined as being suitable for haemodialysis.

- It is recommended that all suitable patients should be offered the choice between home haemodialysis or haemodialysis in a hospital/satellite unit.
- In general, patients suitable for home haemodialysis will be those who:
    - Have the ability and motivation to learn to carry out the process and the commitment to maintain treatment
    - Are stable on dialysis
    - Are free of complications and significant concomitant disease that would render home haemodialysis unsuitable or unsafe
    - Have good functioning vascular access
    - Have a carer who has (or carers who have) also made an informed decision to assist with the haemodialysis unless the individual is able to manage on his or her own
    - Have suitable space and facilities or an area that could be adapted within their home environment
- A full assessment of the patient's clinical needs, social circumstances, and home environment is necessary to determine his or her suitability for home haemodialysis. In order to make an informed choice about the location of haemodialysis that is most suitable for their particular circumstances, patients and all potential carers should be fully informed regarding what is involved in the different options, and the potential impact on their lives and those of their households should be discussed. All potential carer(s) should be given the opportunity to express their views independently of the patient. An opportunity to review the decision to proceed or continue with home haemodialysis should be available in the event of any change in circumstances.
- Patients currently treated in hospital who are potentially suitable for home haemodialysis on clinical grounds, but who have not previously been offered a choice, should be reassessed and informed about their dialysis options.
- Patients performing haemodialysis at home and their carers will require initial training and an accessible and responsive support service. The support service should offer the possibility of respite hospital/satellite unit dialysis as required.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate use of home and hospital/satellite unit haemodialysis for patients with end-stage renal failure

POTENTIAL HARMS

Home haemodialysis is associated with the same potential complications as hospital haemodialysis, such as low blood pressure, air embolus or blood loss.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guidance represents the view of the Institute which was arrived at after careful consideration of the available evidence. Health professionals are expected to take it fully into account when exercising their clinical judgement. This guidance does not, however, override the individual responsibility of health professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

- National Health Service (NHS) Trusts currently offering haemodialysis for patients with end-stage renal failure (ESRF) and all clinicians involved in the care of these patients should review policies and practices regarding offering home haemodialysis to take account of the guidance (see the "Major Recommendations" field).
- Local guidelines or care pathways on haemodialysis should incorporate the guidance (see the "Major Recommendations" field).
- To measure compliance locally with the guidance, the following criteria may be used. Further details on suggestions for audit are presented in Appendix D in the original guideline document.
    - A patient who needs haemodialysis or one who is currently on haemodialysis in a hospital or satellite centre, and who is potentially suitable for home haemodialysis on clinical grounds, but has not previously been offered that choice, is assessed for suitability for home haemodialysis.
    - A patient selected for or currently receiving haemodialysis in a hospital or satellite unit is offered the option of home haemodialysis when the following are present. The patient:
        - Has the ability and motivation to learn to carry out the process
        - Has the commitment to maintain treatment
        - Is stable on dialysis

        - Is free of complications and significant concomitant disease that would render home haemodialysis unsuitable or unsafe
        - Has good functioning vascular access
        - Has a carer who has (or carers who have) also made an informed decision to assist with the haemodialysis unless the individual is able to manage on his or her own
        - Has suitable space and facilities or an area that could be adapted within the home environment
    - The patient and all potential carers make an informed choice as to the most suitable location for treatment.
    - An initial training programme is provided for both the patient and his or her carer(s).
    - The patient on home haemodialysis and his or her carers have an accessible and responsive support service.
    - The patient on home haemodialysis has an opportunity to review the decision to proceed or continue with home haemodialysis in the event of any change in circumstances.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Institute for Clinical Excellence (NICE). Guidance on home compared with hospital haemodialysis for patients with end-stage renal failure. London (UK): National Institute for Clinical Excellence (NICE); 2002 Sep. 20 p. (Technology appraisal guidance; no. 48).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Sep (reviewed 2005)

GUIDELINE DEVELOPER(S)

National Institute for Health and Clinical Excellence (NICE) - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Health and Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Appraisal Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Dr Jane Adam, Radiologist, St George's Hospital, London; Professor R L Akehurst, Dean, School of Health Related Research, Sheffield University; Dr Sunil Angris, General Practitioner, Waterhouses Medical Practice; Professor David Barnett (*Chairman*) Professor of Clinical Pharmacology, University of Leicester; Dr Sheila Bird, MRC Biostatistics Unit, Cambridge; Professor Carol Black, Consultant Physician, Royal Free Hospital & UCL, London; Professor John Brazier, Health Economist, University of Sheffield; Professor Martin Buxton, Director of Health Economics Research Group, Brunel University; Professor Mike Campbell, Statistician, Institute of General Practice & Primary Care, Sheffield; Dr Karl Claxton, Health Economist, University of York; Professor Sarah Cowley, Professor of Community Practice Development, Kings College, London; Professor Jack Dowie, Health Economist, London School of Hygiene & Tropical Medicine, London; Mr Chris Evennett, Chief Executive, Mid-Hampshire Primary Care Trust; Dr Paul Ewings, Statistician, Taunton & Somerset NHS Trust; Professor Terry Feest, Clinical Director and Consultant Nephrologist, Richard Bright Renal Unit, and Chairman of the UK Renal Registry; Professor Gary A Ford, Professor of Pharmacology of Old Age/Consultant Physician, University of Newcastle; Mrs Sue Gallagher, Chief Executive, Merton, Sutton and Wandsworth Health Authority; Dr Trevor Gibbs, Head, Global Clinical Safety & Pharmacovigilance, GlaxoSmithKline; Sally Gooch, Director of Nursing, Mid-Essex Hospital Services Trust; Mr John Goulston, Director of Finance, The Royal Free Hampstead NHS Trust; Professor Trisha Greenhalgh, Professor of Primary Health Care, University College London; Miss Linda Hands, Consultant Vascular Surgeon, John Radcliffe Hospital, Oxford; Professor Philip Home, Professor of Diabetes Medicine, University of Newcastle; Dr Terry John, General Practitioner, The Firs, London; Dr Diane Ketley, Research into Practice Programme Leader, NHS Modernisation Agency; Dr Mayur Lakhani General Practitioner, Highgate Surgery, Leicester, and Lecturer, University of Leicester; Ruth Lesirge, Lay Representative; Director, Mental Health Foundation; Dr George Levvy, Lay Representative; Chief Executive, Motor Neurone Disease Association; Dr Gill Morgan, CEO, North & East Devon Health Authority; Professor

Miranda Mugford, Health Economist, University of East Anglia; Mr M Mughal, Consultant Surgeon, Lancashire Teaching Hospitals NHS Trust; Mr James Partridge, Chief Executive, Changing Faces; Siân Richards, General Manager, Cardiff Local Health Group; Professor Philip Routledge, Professor of Clinical Pharmacology, University of Wales College of Medicine; Dr Rhiannon Rowsell, Pharmaceutical Physician, AstraZeneca UK Ltd; Dr Stephen Saltissi, Consultant Cardiologist, Royal Liverpool University Hospital; Professor Andrew Stevens (*Vice-Chairman*) Professor of Public Health, University of Birmingham; Professor Ray Tallis, Consultant Physician, Hope Hospital, Salford; Dr Cathryn Thomas, General Practitioner, and Senior Lecturer, Department of Primary Care and General Practice, University of Birmingham; Professor Mary Watkins, Head of Institute of Health Studies, University of Plymouth; Dr Norman Waugh, Public Health Consultant, University of Southampton

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

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GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) format from the National Institute for Health and Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Guidance on home compared with hospital haemodialysis for patients with end-stage renal failure. Quick reference guide. London (UK): National Institute for Health and Clinical Excellence (NICE); 2002 Sep. 2 p. (Technology appraisal 48). Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.
- Systematic review of the effectiveness and cost-effectiveness of home versus hospital or satellite unit haemodialysis for people with end stage renal failure. NHS R&D HTA Programme. 2002 Apr. 2. 134 p. Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0161. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria are available in Appendix D of the original guideline document.

PATIENT RESOURCES

The following is available:

- Guidance on the use of haemodialysis in the home and in hospital. London (UK): National Institute for Health and Clinical Excellence (NICE); 2002 Sep. 8 p. (Technology appraisal 48).

Electronic copies: Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Health and Clinical Excellence (NICE) Web site.

Print copies: Available from the NHS Response Line 0870 1555 455. ref: N0162. 11 Strand, London, WC2N 5HR.

NGC STATUS

This NGC summary was completed by ECRI on January 31, 2007.

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