Canadian Consensus Development Conference on Surveillance and Screening for AROs
Reading of the Consensus Statement
Introductory Comments by the Jury Chair, Dr. Tom Marrie
June 20, 2014

On behalf of the jury I would like to thank you for the honor of participating in this exercise which has the potential to markedly improve infection control in Canada.

We would like to thank Alberta Health and Minister Horne for the courage to allow a group like us to provide advice.

We would not have been able to complete our task without Mr. Steve Buick, Hana Price and staff from IHE.

Now a few words about how we developed the product you see in front of you. We listened carefully; and not unexpectedly, like the presenters, we did not always have the same interpretation of the data.

We initially answered each of the questions in the program, and by 8 pm or so last night we had a 26-page document of more than 10,000 words.

Andre and Steven suggested we condense each section into key findings and then link the recommendations to the key findings. So apart from the introduction and the overview, that is what you have in front of you.

While our mandate was to make recommendations that are applicable beyond Alberta, we have as an overriding focus the concept that Alberta with its single health district, excellent human resources within infection control/ infectious diseases/medical microbiology, should be a living laboratory to examine – in a cluster randomized trial or trials – many of the practices about which there is no evidence base.

On page 5 there are 6 factors that must be taken into account when considering our recommendations:

1. The problem should be conceived as multi-factorial – there is no single cause or explanation for infection rates and variations among facilities and communities.
2. A holistic approach that extends across sectors and includes primary prevention is more likely to yield better and more durable results than treating AROs in isolation in hospitals.
3. Simpler and less costly strategies should be pursued before more complex and expensive strategies.
4. A higher standard of evidence should be required to support the more costly and time-consuming interventions.
5. Policies and practices should be considered provisional and subject to ongoing research and evaluation. AROs and their consequences are a constantly moving target requiring ongoing surveillance.
6. It is essential to conduct real-world trials of all interventions to assess their effectiveness.

I would now like to review the recommendations one by one with you. May I suggest I go through all the recommendations which my colleagues will be glad to answer?

4-9 Major management prevention strategies:
Note these come as a package. We did have considerable debate about recommending no universal screening. We do feel this can be done safely, if my recommendations 5 to 9 exist or are implemented concurrently.

Organizational and environmental strategies:
These 9 recommendations are key. If attention is not paid to these, success would be difficult to achieve even if you implement all the others.

I will now go through them one by one.

Recommendations 19 and 20, speak to ethics and patient engagement. We cannot overemphasize plain language communication with patients and their families.

More attention must be paid to minimizing the adverse effects of isolation.

Lastly, but probably the two key recommendations center around the research agenda.

This is where a made-in-Alberta solution can be generalized to the rest of the country and beyond. Adequate dedicated funding is necessary to make this happen. As a ballpark figure, $15-20 million/year should work. At the end of 5 years a rigorous evaluation by a panel of international experts would recommend continuance or dissolution.

I would now like to ask my colleagues if they have anything to add.