



Outpatient Dialysis Center Practices Survey

Form Approved
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www.cdc.gov/nhsn

Complete this survey as described in the Dialysis Event Protocol.

Instructions: Complete one survey per center. Surveys are completed for the current year. It is strongly recommended that the survey is completed in February of each year by someone who works in the center and is familiar with current practices within the center. Complete the survey based on the actual practices at the center, not necessarily the center policy, if there are differences. For complete instructions on the survey questions, please see the "Instructions for the Outpatient Dialysis Center Practices Survey" document available at: <http://www.cdc.gov/nhsn/dialysis/dialysis-event.html#dcf>.

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*required to save as complete

Facility ID#: _____	*Survey Year: _____
A. Dialysis Center Information	
A.1. General	
<p>*1. Ownership of your dialysis center (choose one): <input type="checkbox"/> Government <input type="checkbox"/> Not for profit <input type="checkbox"/> For profit</p> <p>*2. Location/hospital affiliation of your dialysis center (choose one): <input type="checkbox"/> Freestanding <input type="checkbox"/> Hospital based <input type="checkbox"/> Freestanding but owned by a hospital</p> <p>*3. Types of dialysis services offered (select all that apply): <input type="checkbox"/> In-center daytime hemodialysis <input type="checkbox"/> In-center nocturnal hemodialysis <input type="checkbox"/> Peritoneal dialysis <input type="checkbox"/> Home hemodialysis</p> <p>*4. Number of in-center hemodialysis stations: _____</p> <p>*5. Is your center part of a group or chain of dialysis centers? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, name of group or chain: _____</p> <p>*6. Do you (the person primarily responsible for collecting data for this survey) perform patient care in the dialysis center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*7. Is there someone at your dialysis center in charge of infection control? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, which best describes this person? (if >1 person in charge, select all that apply) <input type="checkbox"/> Hospital-affiliated or other infection control practitioner comes to our unit <input type="checkbox"/> Dialysis nurse or nurse manager <input type="checkbox"/> Dialysis center administrator or director <input type="checkbox"/> Dialysis education specialist <input type="checkbox"/> Other, specify: _____</p> <p>*8. Is there a dedicated vascular access nurse/coordinator (either full or part-time) at your center? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
A.2. Isolation and Screening	
<p>*9. Does your center have capacity to isolate patients with hepatitis B? <input type="checkbox"/> Yes, use hepatitis B isolation room <input type="checkbox"/> Yes, use hepatitis B isolation area <input type="checkbox"/> No hepatitis B isolation</p>	
<p>Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).</p> <p>Public reporting burden of this collection of information is estimated to average 1.75 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).</p>	
<p>CDC 57.500 (Front) Rev 4, V 8.1</p>	

A.2. Isolation and Screening (continued)

- *10. Indicate any other conditions for which patients are isolated or cohorted for treatment within your center (select all that apply):
- | | | |
|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Active tuberculosis (TB) |
| <input type="checkbox"/> Vancomycin-resistant <i>Enterococcus</i> (VRE) | <input type="checkbox"/> <i>Clostridium difficile</i> (C. Diff.) | |
| <input type="checkbox"/> Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA) | <input type="checkbox"/> Other, specify: _____ | |
- *11. Does your center routinely screen patients for tuberculosis (TB) on admission to your center? Yes No

A.3. Patient Records

- *12. Does your center routinely maintain records of patients' hemodialysis **station** assignment? Yes No
- *13. Does your center routinely maintain records of patients' hemodialysis **machine** assignment? Yes No
- *14. If a patient from your center was hospitalized, how often is your center able to determine if a bloodstream infection contributed to their hospital admission?
- | | | | | | |
|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | <input type="checkbox"/> N/A – not pursued |
|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|--|
- *15. How often is your center able to obtain a patient's microbiology lab records from a hospitalization?
- | | | | | | |
|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|--|
| <input type="checkbox"/> Always | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never | <input type="checkbox"/> N/A – not pursued |
|---------------------------------|--------------------------------|------------------------------------|---------------------------------|--------------------------------|--|

Please respond to the following questions based on information from your center for the first week of February (applies to current or most recent February relative to current date).

B. Patient and staff census

- *16. Was your center operational during the first week of February? Yes No
- *17. How many MAINTENANCE, NON-TRANSIENT dialysis **PATIENTS** were assigned to your center during the first week of February? _____
Of these, indicate the number who received:
- | | |
|----------------------------------|--|
| a. In-center hemodialysis: _____ | |
| b. Home hemodialysis: _____ | |
| c. Peritoneal dialysis: _____ | |
- *18. How many **PATIENT CARE** staff (full time, part time, or affiliated with) worked in your center during the first week of February? *Include only staff who had direct contact with dialysis patients or equipment.* _____
Specify the number of persons by category:
- | | |
|--|--|
| a. Nurse/nurse assistant: _____ | e. Dietitian: _____ |
| b. Dialysis patient-care technician: _____ | f. Physicians/physician assistant: _____ |
| c. Dialysis biomedical technician: _____ | g. Nurse practitioner: _____ |
| d. Social worker: _____ | h. Other: _____ |

C. Vaccines

- *19. Of the patients counted in question 17, how many received:
- | |
|---|
| a. At least 3 doses of hepatitis B vaccine (ever)? _____ |
| b. The influenza (flu) vaccine for the <u>current/most recent</u> flu season? _____ |
| c. The pneumococcal vaccine (ever)? _____ |
- *20. Of your MAINTENANCE, NON-TRANSIENT hemodialysis patients from question 17 (17a + 17b), how many received at least 3 doses of hepatitis B vaccine (ever)? _____

- *21. Of the patient care staff members counted in question 18, how many received:
- a. At least 3 doses of hepatitis B vaccine (ever)? _____
 - b. The influenza (flu) vaccine for the current/most recent flu season? _____
- *22. Does your center use standing orders to allow nurses to administer some or all vaccines to patients without a specific physician order?
- Yes
 No
- *23. Which type of pneumococcal vaccine does your center offer to **patients**? (choose one)
- Polysaccharide (i.e., PPSV23) only
 Conjugate (e.g., PCV13) only
 Both polysaccharide & conjugate
 Offered, but type unknown
 Neither offered

D. Hepatitis B and C

D.1. Hepatitis B

- *24. Of the MAINTENANCE, NON-TRANSIENT in-center hemodialysis PATIENTS from question 17a:
- a. How many were hepatitis B surface **ANTIGEN** (HBsAg) positive in the first week of February?

 - i. Of these patients who were hepatitis B surface **ANTIGEN** (HBsAg) positive in the first week of February, how many were positive when first admitted to your center? _____
 - b. How many patients converted from hepatitis B surface ANTIGEN (HBsAg) negative to positive during the prior 12 months (*i.e., in the past year, how many patients had newly acquired hepatitis B virus infection, not as a result of vaccination*)? Do not include patients who were antigen positive before they were first dialyzed in your center. _____

D.2. Hepatitis C

- *25. Does your center routinely screen hemodialysis patients for **hepatitis C** antibody (anti-HCV) on admission to your center? (Note: This is NOT hepatitis B core antibody) Yes No
- *26. Does your center routinely screen hemodialysis patients for hepatitis C antibody (anti-HCV) at any other time? Yes No
- a. If yes, how frequently?
 Twice annually Annually Other, specify: _____
- *27. Of the MAINTENANCE, NON-TRANSIENT in-center hemodialysis patients counted in question 17a,
- a. How many were hepatitis C antibody positive in the first week of February? _____
 - i. Of these patients who were hepatitis C antibody positive in the first week of February, how many were positive when first admitted to your center? _____
 - b. How many patients converted from hepatitis C antibody negative to positive during the prior 12 months (*i.e., in the past year, how many patients had newly acquired hepatitis C infection*)? Do not include patients who were anti-HCV positive before they were first dialyzed in your center. _____

E. Dialysis Policies and Practices

E.1. Dialyzer Reuse

- *28. Does your center reuse dialyzers for some or all patients? Yes No
- If yes,
- a. Where are dialyzers reprocessed?
 Dialyzers are reprocessed at our center only
 Dialyzers are transported to an off-site facility for reprocessing only
 Both at our center and off-site

E.1. Dialyzer Reuse (continued)		
	<p>b. If your center reuses dialyzers for some or all patients, are dialyzers refrigerated before reprocessing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. How is dialyzer header cleaning performed? (select all that apply)</p> <p><input type="checkbox"/> Automated machine (e.g., RenaClear® System)</p> <p><input type="checkbox"/> Spray device (e.g., ASSIST® header cleaner)</p> <p><input type="checkbox"/> Insertion of twist-tie or other instrument to break up clots</p> <p><input type="checkbox"/> Disassemble dialyzer to manually clean</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><input type="checkbox"/> No separate header cleaning step performed</p> <p>d. Is there a limit to the number of times a dialyzer is used?</p> <p><input type="checkbox"/> Yes (indicate number): _____</p> <p><input type="checkbox"/> No limit as long as dialyzer meets certain criteria (e.g., passes pressure leak test, etc.)</p>	
E.2. Dialysate		
*29.	What type of dialysate is used for in-center hemodialysis patients at your center? (choose one)	
	<input type="checkbox"/> Conventional <input type="checkbox"/> Ultrapure	
*30.	Does your center routinely test dialysate from the patient's machine for culture and endotoxin whenever a patient has a pyrogenic reaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E.3. Priming Practices		
*31.	Does your center use hemodialysis machine Waste Handling Option (WHO) ports?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*32.	Are any patients in your center "bled onto the machine" (i.e., where blood is allowed to reach or almost reach the prime waste receptacle or WHO port)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E.4. Injection Practices		
*33.	What form of erythropoiesis stimulating agent (ESA) is most often used in your center?	
	<input type="checkbox"/> Single-dose vial <input type="checkbox"/> Multi-dose vial <input type="checkbox"/> Pre-packaged syringe <input type="checkbox"/> N/A	
	a. Is ESA from one single-dose vial or syringe administered to more than one patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No
*34.	Where are medications <u>most commonly</u> drawn into syringes to prepare for patient administration? (choose one)	
	<input type="checkbox"/> At the individual dialysis stations <input type="checkbox"/> On a mobile medication cart within the treatment area <input type="checkbox"/> At a fixed location within the patient treatment area (e.g., at nurses' station) <input type="checkbox"/> At a fixed location removed from the patient treatment area (not a room) <input type="checkbox"/> In a separate medication room <input type="checkbox"/> In a pharmacy <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> N/A	
*35.	Do technicians administer any IV medications or infusates (e.g., heparin, saline) in your center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E.5. Antibiotic Use		
*36.	Indicate whether your center uses any of the following means to restrict or ensure appropriate antibiotic use:	
		Yes No
	a. Have a written policy on antibiotic use	<input type="checkbox"/> <input type="checkbox"/>
	b. Formulary restrictions	<input type="checkbox"/> <input type="checkbox"/>
	c. Antibiotic use approval process	<input type="checkbox"/> <input type="checkbox"/>
	d. Automatic stop orders for antibiotics	<input type="checkbox"/> <input type="checkbox"/>

E.6. Prevention Activities

- *37. Has your center participated in any national or regional infection prevention-related initiatives? Yes No
- a. If yes, indicate the primary focus of the initiative(s): (if >1 initiative, select all that apply)
- Catheter reduction
 - Hand hygiene
 - Bloodstream infection prevention
 - Patient education on infection prevention
 - Increasing vaccination rates
 - Decrease use of antibiotics
 - Improving general infection control
 - Improving culture of safety
 - Other, specify: _____
- *38. Does your center follow CDC-recommended Core Interventions to prevent bloodstream infections in hemodialysis patients? Yes No Don't know
- *39. Does your center perform hand hygiene audits of staff monthly (or more frequently)? Yes No
- *40. Does your center perform observations of staff vascular access care and catheter accessing practices quarterly (or more frequently)? Yes No
- *41. Does your center perform staff competency assessments for vascular access care and catheter accessing annually (or more frequently)? Yes No

E.7. Peritoneal Dialysis

- *42. For **peritoneal dialysis catheters**, is antimicrobial ointment routinely applied to the exit site during dressing change? Yes No N/A
- a. If yes, what type of ointment is most commonly used? (choose one)
- Gentamicin Bacitracin/polymyxin B (e.g., Polysporin®)
 - Mupirocin Bacitracin/neomycin/polymyxin B (triple antibiotic)
 - Povidone-iodine Bacitracin/gramicidin/polymyxin B (Polysporin® Triple)
 - Other, specify: _____

F. Vascular Access

F.1. General Vascular Access Information

- *43. Of your MAINTENANCE, NON-TRANSIENT hemodialysis patients from question 17 (17a + 17b), how many received hemodialysis through each of the following access types during the first week of February?
- a. AV fistula _____
 - b. AV graft _____
 - c. Tunneled central line _____
 - d. Nontunneled central line _____
 - e. Other access device (e.g., catheter-graft hybrid) _____

F.2. Arteriovenous (AV) Fistulas or Grafts

- *44. Before prepping the fistula or graft site for cannulation, the site is most often cleansed with:
- Soap and water Alcohol-based hand rub Other, specify: _____ Nothing

F.2. Arteriovenous (AV) Fistulas or Grafts (continued)

*45. Before cannulation of a fistula or graft, the site is most often prepped with (select the one most commonly used):

- Alcohol
- Chlorhexidine without alcohol
- Chlorhexidine with alcohol (e.g., Chloraprep®, Chlorascrub™)
- Povidone-iodine (or tincture of iodine)
- Sodium hypochlorite solution (e.g., ExSept®, Alcavis)
- Other, specify: _____
- Nothing

a. Indicate the form of skin antiseptic used to prep fistula/graft sites:

- Multiuse bottle (e.g., poured onto gauze)
- Pre-packaged swabstick/spongstick
- Pre-packaged pad
- Other, specify: _____

*46. How many of your fistula patients undergo buttonhole cannulation?

- All Most Some None

If any,

a. Which fistula patients undergo buttonhole cannulation:

- In-center hemodialysis patients only Home hemodialysis patients only Both

b. Is antimicrobial ointment (e.g., mupirocin) routinely used at buttonhole cannulation sites to **prevent** infection? Yes No

c. If buttonhole cannulation is performed for in-center hemodialysis patients, it is most often performed by:

- Nurse Patient (self-cannulation) Technician Other, specify: _____

F.3. Hemodialysis Catheters

*47. Before accessing the hemodialysis catheter, the **catheter hubs** are most commonly prepped with (select the one most commonly used):

- Alcohol
- Chlorhexidine without alcohol
- Chlorhexidine with alcohol (e.g., Chloraprep®, Chlorascrub™)
- Povidone-iodine (or tincture of iodine)
- Sodium hypochlorite solution (e.g., Alcavis)
- Other, specify: _____
- Nothing

a. Indicate the form of antiseptic/disinfectant used to prep the catheter hubs:

- Multiuse bottle (e.g., poured onto gauze) Other, specify: _____
 Pre-packaged swabstick/spongstick Pre-packaged pad

*48. Are catheter hubs routinely scrubbed after the cap is removed and before accessing the catheter (or before accessing the catheter via a needleless connector device, if one is used)? Yes No

F.3. Hemodialysis Catheters (continued)

- *49. When the catheter dressing is changed, the exit site (i.e., place where the catheter enters the skin) is most commonly prepped with (select the one most commonly used):
- Alcohol
 - Chlorhexidine without alcohol
 - Chlorhexidine with alcohol (e.g., Chloraprep®, Chlorascrub™)
 - Povidone-iodine (or tincture of iodine)
 - Sodium hypochlorite solution (e.g., ExSept®, Alcavis)
 - Other, specify: _____
 - Nothing
- a. Indicate the form of antiseptic/disinfectant used at the exit site:
- Multiuse bottle (e.g., poured onto gauze) Other, specify: _____
 - Pre-packaged swabstick/spongstick Pre-packaged pad
- *50. For **hemodialysis catheters**, is antimicrobial ointment routinely applied to the exit site during dressing change? Yes No
- a. If yes, what type of ointment is most commonly used? (select the one most commonly used)
- Bacitracin/gramicidin/polymyxin B (Polysporin® Triple) Gentamicin
 - Bacitracin/polymyxin B (e.g., Polysporin®) Mupirocin
 - Bacitracin/neomycin/polymyxin B (triple antibiotic) Povidone-iodine
 - Other, specify: _____
- *51. Job classification of staff members who most often perform hemodialysis catheter care (i.e., access catheters or perform exit site care) in your center (choose one):
- Nurse Technician Other, specify: _____
- *52. Are antimicrobial lock solutions routinely used to **prevent** hemodialysis catheter infections in your center?
- Yes, for all catheter patients Yes, for some catheter patients No
- If yes,
- a. Indicate the lock solution most commonly used (select the one most commonly used):
- Sodium citrate Taurolidine
 - Gentamicin Ethanol
 - Vancomycin Multi-component lock solution or other, specify: _____
- *53. Are needleless closed connector devices used on hemodialysis catheters in your center? Yes No
- If yes,
- a. Indicate what kind: Tego® Q-Syte™ Other, specify: _____
- b. Indicate for what patients: In-center hemodialysis patients only Home hemodialysis patients only Both
- *54. Are any of the following used for hemodialysis catheters in your center? (select all that apply)
- Antimicrobial-impregnated hemodialysis catheters
 - Chlorhexidine dressing (e.g., Biopatch®, Tegaderm™ CHG)
 - Other antimicrobial dressing (e.g., silver-impregnated)
 - Antiseptic-impregnated catheter cap (e.g., Curoc® Port Protector)
 - None of the above

Comments: