

OMB No. 0920-0666

Exp. Date: xx-xx-xxxx

	Page 1 of 4 * required				
acilit	*Survey Year:				
A. Fa	cility Information				
*1 .	Ownership of your dialysis center (choose one): \square Government \square Not for profit \square For Profit				
[*] 2.	Location/hospital affiliation of your dialysis center: \Box Freestanding \Box Hospital based \Box Freestanding but owned by a hospital				
[*] 3.	Types of dialysis services offered (check all that apply):				
	\square In-center hemodialysis \square Peritoneal dialysis \square Home hemodialysis				
[*] 4.	Number of in-center hemodialysis stations:				
5 .	Is your facility part of a group or chain of dialysis centers? Yes No If Yes, name of group or chain: Da Vita Dialysis Clinic Inc. (DCI) Fresenius Medical Care American Renal Assoc. Nat'l Renal Alliance Nat'l Renal Institutes Dialysis Corp. of America Renal Research Institute Satellite Healthcare Renal Advantage Inc Liberty Dialysis Renal Care Partners Other (specify):				
[*] 6.	Do you (the person primarily responsible for collecting data for this survey) perform patient care in this dialysis unit? Yes No				
' 7.	Is there someone at your unit in charge of infection control? Yes No If Yes, which best describes this person? Hospital-affiliated or other infection control practitioner comes to our unit Dialysis nurse or nurse manager Dialysis facility administrator or director Dialysis education specialist Other dialysis staff (specify):				
[≮] 8.	Is there a dedicated vascular access nurse/coordinator at your facility? Yes No				
[*] 9.	Does your unit have capacity to isolate hepatitis B? \square Yes, use hepatitis B isolation room				
	\square Yes, use hepatitis B isolation area $\ \square$ No hepatitis B isolation				
[*] 10.	Indicate any other conditions that are isolated in your unit (check all that apply): $\ \square$ None				
	\square Hepatitis C \square Tuberculosis (TB) \square MRSA \square Other (specify):				

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)). Public reporting burden of this collection of information is estimated to average 1 hour 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).



OMB No. 0920-0666 Exp. Date: xx-xx-xxxx

Sa	Page 2 of 4 Outpatient Dialysis C	enter Practic	es Survey	Exp. Date: xx-x	x-xxx	
A. Fa	cility Information (continued)					
*11. Please indicate whether the following types of records are available to staff or an administrator in your unit (check all that apply):						
		Yes, available	Yes, available electronically	Not available		
	Local hospital microbiology lab results (i.e., for cultures sent to hospital lab or patients during hospitalization)					
	Hemodialysis station & machine assignment					
	Staff immunizations					
Please respond to the following questions based on records from your facility for the first week of January (applies to current or most recent January relative to current date).						
B. Pa	tient and staff census					
*12. *13.	week of January? Of these, please indicate the number who received: a. in-center hemodialysis: b. home hemodialysis: c. peritoneal dialysis:					
	ccines					
*14.	Of the <u>patients</u> counted in question 12, how many received: a. at least 3 does of hepatitis B vaccine (ever)? b. the influenza (flu) vaccine for <u>this</u> flu season (September or later)? c. the pneumococcal vaccine (ever)?					
*15.	Does your facility use standing orders to allow nur specific physician order?	rses to administer v	accines to patients	s without a		
	\square Yes, for some or all vaccines					
	\square No, not for any vaccines					
*16.	Of the patient care <u>staff members</u> counted in question 13, how many received: a. at least 3 doses of hepatitis B vaccine (ever)?: b. the influenza (flu) vaccine for this flu season (September or later)?:					
*17.	Please indicate whether your facility offers the fo	llowing immunization	ons: Yes N	o		
	a. influenza vaccine offered to patientsb. influenza vaccine offered to patient carc. pneumococcal vaccine offered to patie]		



OMB No. 0920-0666 Exp. Date: xx-xx-xxxx

Page 3 of

CDC57.104(Back) Rev 2, v6.4

	age 5 of 4			
*18.	Of your CHRONIC, NON-TRANSIENT hemodialysis patients from question 12 (12a + 12b), indicate the number with each of the following access types during the first week of January (patients with > 1 access type should be counted in each applicable category):			
	AV fistula Tunneled central line			
	AV graft Nontunneled central line			
	Hybrid access (e.g., graft-catheter)			
D. He	patitis B and C			
*19. Of your CHRONIC, NON-TRANSIENT in-center <u>hemodialysis</u> PATIENTS from question 12a: a. How many converted from hepatitis B surface ANTIGEN (HBsAg) negative to positive in the past 12 mont had newly acquired hepatitis B virus infection, not as a result of vaccination)? Do not include patients who we antigen positive before they were first dialyzed in your center:				
	b. How many were hepatitis B surface antigen (HBsAg) positive on arrival to your center?			
*20.	Of the patients counted in question 12a., were all or almost all tested for hepatitis B surface ANTIBODY (anti-HBs) in the past 12 months? Yes No If Yes, how many were positive?			
*21.	Does your facility routinely test hemodialysis patients for hepatitis C antibody (anti-HCV)? (Note: This is NOT hepatitis B core antibody)? \Box Yes, every 6 months \Box Yes, every 12 months			
	☐ No (not done or less frequently than yearly)			
	If Yes, Of the patients counted in question 12a., a. How many converted from anti-HCV negative to positive during the past 12 months (i.e., had newly acquired hepatitis C infection)? Do not include patients who were anti-HCV positive before they were first dialyzed in your center:			
	b. How many were positive for hepatitis C antibody on arrival to your center?			
E. Dia	lysis Policies and Practices			
*22.	Does your facility reuse dialyzers for some or all patients? Yes No If Yes,			
	a. What method is used to disinfect the majority of these dialyzers?			
	\square Amuchina \square Glutaraldehyde (e.g., Diacide®) \square Peracetic acid (e.g., Renalin®)			
	☐ Formaldehyde ☐ Heat ☐ Other			
	b. Is bleach also used to clean the inside of these dialyzers? Yes No			
	c. Where are dialyzers reprocessed? \qed Dialyzers are reprocessed at our facility			
	\square Dialyzers are transported to an off-site facility for reprocessing			
	\square Both at our facility and off-site			
	d. Are dialyzers refrigerated before reprocessing? Yes No			
*23.	Where are medications from multidose vials most commonly drawn into syringes to prepare for patient administration?			
	$\hfill \square$ On a mobile medication cart within the treatment area or at the individual dialysis stations			
	$\ \square$ In a separate medication room or in a medication area separate from the patient treatment area			
	☐ At a fixed location within the dialysis unit, not separated by walls from the rest of the patient treatment area			
	☐ Other (specify):			



OMB No. 0920-0666 Exp. Date: xx-xx-xxxx

Page 4 of 4

CDC57.104(Back) Rev 2, v6.4

*24.	What type of erythropoietin vials are generally used in your facilit erythropoietin from a single-dose vial administered to more than					
*25.	Please indicate whether your facility uses any of the following means of restricting or ensuring appropriate antibiotic					
	use? Yes	No				
	a. have a written policy on antibiotic use $\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \$					
	b. formulary restrictions					
	c. antibiotic use approval process d. automatic stop orders for antibiotics					
	·					
F. Vas	ascular Access					
*26.	For AV grafts or fistulas: a. Before prepping the area for puncture, is the area commonly <u>washed</u> with soap and water? Yes No b. Before puncture of a graft or fistula, the area is most often <u>prepped</u> with:					
	\square Alcohol \square Chlorhexidine (e.g., Chloraprep®) \square Povidor	ne-iodine (or tincture of iodine)				
	☐ Sodium hypochlorite solution (e.g., ExSept®) ☐ Other (s c. Is buttonhole cannulation performed on any patients in your fac					
*27.	. Job classification of staff members $\underline{\text{primarily}}$ responsible for provious or change dressing) (select one): \square Nurse \square Technician	ding hemodialysis catheter care (i.e., access catheters				
*28.	For hemodialysis catheters: a. Before access of the hemodialysis catheter, the catheter ports are prepped with (check the one most commonly used): Alcohol Chlorhexidine (e.g., Chloraprep®) Povidone-iodine (or tincture of iodine) Sodium hypochlorite solution (e.g., ExSept®, Alcavis) Other (specify): Nothing b. When the catheter dressing is changed, the exit site (i.e. place where the catheter enters the skin) is cleansed with (check the one mostly commonly used):					
	☐ Alcohol ☐ Chlorhexidine (e.g., Chloraprep®) ☐ Povidone-iodine (or tincture of iodine)					
	☐ Sodium hypochlorite solution (e.g., ExSept®, Alcavis) ☐ Oth					
*29.	. Are antimicrobial lock solutions used to <u>prevent</u> hemodialysis cat	heter infections in your unit?				
	\square Yes, for all catheter patients \square Yes, for some catheter patients \square No					
	If yes, indicate the lock solutions used (check all that apply): $\ \ \Box$	Sodium citrate 🔲 Gentamicin				
	□ Vancomycin □ Taurolidine □ Ethanol □ Other (specified For hemodialysis catheters, is antibacterial ointment routinely Yes No					
*30.		oorin®) 🗆 Povidone-iodine				
	☐ Mupirocin ☐ Other (specify):					
*31.	. For peritoneal dialysis catheters , is antibacterial ointment rou Yes No N/A	tinely applied to exit site during dressing change?				
	If Yes, what type of ointment? \square Bacitracin/polymixin (e.g., Polysp	porin $oldsymbol{@}$) \square Gentamicin				
	\square Mupirocin \square Other (specify):					
*32.	 Are any of the following used to prevent hemodialysis catheter-re Antimicrobial-impregnated hemodialysis catheters □ Chlorhexic Closed connector luer access devices (e.g., Tego® or Q-Syte™) 					