OMB No. 0920-0666
Exp. Date: xx/xx/20xx
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Patient Safety Component—
Outpatient Dialysis Center Practices Survey

Complete this survey as indicated by the Dialysis Event Protocol.

Instructions: Complete one survey per facility. Surveys are completed for the current year. It is strongly recommended to complete the survey in January of each year. The survey should be completed by someone who works in the facility and is familiar with current practices. Complete the survey based on the actual practices at the facility, not necessarily the facility policy, if there are differences.

*required for saving

Facility ID#: _____ *Survey Year: _____

A. Facility Information

*1. Ownership of your dialysis center (choose one):
☐ Government ☐ Not for profit ☐ For profit

*2. Location/hospital affiliation of your dialysis center:
☐ Freestanding ☐ Hospital based ☐ Freestanding but owned by a hospital

*3. Types of dialysis services offered (select all that apply):
☐ In-center hemodialysis ☐ Peritoneal dialysis ☐ Home hemodialysis

*4. Number of in-center hemodialysis stations: _____

*5. Is your facility part of a group or chain of dialysis centers? ☐ Yes ☐ No
a. If Yes, owned by: _____
b. If Yes, managed or operated by: _____

*6. Do you (the person primarily responsible for collecting data for this survey) perform patient care in the dialysis facility? ☐ Yes ☐ No

*7. Is there someone at your dialysis facility in charge of infection control? ☐ Yes ☐ No
a. If Yes, which best describes this person? (if >1 person in charge, select all that apply)
☐ 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 (either full or part-time) at your facility? ☐ Yes ☐ No

*9. Does your facility have capacity to isolate hepatitis B?
☐ Yes, use hepatitis B isolation room ☐ Yes, use hepatitis B isolation area ☐ No hepatitis B isolation

*10. Indicate any other conditions that are routinely isolated or cohorted for treatment <u>within your facility</u>:
☐ None ☐ Hepatitis C ☐ Tuberculosis (TB)
☐ Methicillin-resistant *Staphylococcus aureus* (MRSA) ☐ 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 1.5 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).

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A. Facility Information (continued)

*11. Please indicate whether the following types of records are typically available to staff or an administrator in your facility (select 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. Patient and staff census

*12. How many MAINTENANCE, NON-TRANSIENT dialysis **PATIENTS** were assigned to your center during the first week of January? _____
Of these, indicate the number who received:

a. In-center hemodialysis: _____
b. Home hemodialysis: _____
c. Peritoneal dialysis: _____

*13. How many **PATIENT CARE** staff (full time, part time, or affiliated with) worked in your facility during the first week of January? *Include only staff who had direct contact with dialysis patients or equipment*: _____
Specify the number of persons by category:

a. Nurse/nurse assistant: _____
b. Dialysis patient-care technician: _____
c. Dialysis biomedical technician: _____
d. Social worker: _____
e. Dietitian: _____
f. Physicians/physician assistant: _____
g. Nurse practitioner: _____
h. Other: _____

C. Vaccines

*14. Of the patients counted in question 12, 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)? _____
c. The pneumococcal vaccine (ever)? _____

*15. Of your MAINTENANCE, NON-TRANSIENT hemodialysis patients from question 12 (12a +12b), how many received at least 3 doses of hepatitis B vaccine (ever)?_____

*16. Of the patient care staff members 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. Does your facility use standing orders to allow nurses to administer vaccines to patients without a specific physician order?

☐ Yes, for some or all vaccines
☐ No, not for any vaccines

*18. Indicate whether your facility offers the following immunizations:

	Yes	**No**
a. Influenza vaccine offered to **patients**	☐	☐

b. Influenza vaccine offered to patient care staff ☐ ☐
c. Pneumococcal vaccine offered to **patients** ☐ ☐

D. Hepatitis B and C

*19. Of your MAINTENANCE, NON-TRANSIENT in-center hemodialysis PATIENTS from question 12a:

a. How many were hepatitis B surface **ANTIGEN** (HBsAg) positive in the first week of January? _____

b. How many converted from hepatitis B surface ANTIGEN (HBsAg) negative to positive in the prior 12 months (*i.e., 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*: _____

c. 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

a. If Yes, how many were positive in the first week of January? _____

*21. Does your facility routinely test hemodialysis patients for **hepatitis C** antibody (anti-HCV)? ☐ Yes ☐ No (*Note: This is NOT hepatitis B core antibody*)

a. If Yes, how frequently? (select all that apply)

☐ On admission ☐ Twice annually ☐ Once annually ☐ Less than annually

Of the patients counted in question 12a,

b. How many were hepatitis C virus (anti-HCV) antibody positive in the first week of January? _____

c. How many converted from anti-HCV negative to positive during the prior 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*: _____

d. How many were positive for hepatitis C antibody on arrival to your center? _____ ☐ No admission testing done

E. Dialysis 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?

☐ Amuchina ☐ Glutaraldehyde (e.g., Diacide®) ☐ 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?

☐ Dialyzers are reprocessed at our facility
☐ Dialyzers are transported to an off-site facility for reprocessing
☐ Both at our facility and off-site

d. Are dialyzers refrigerated before reprocessing? ☐ Yes ☐ No

e. How is dialyzer header cleaning performed? (select all that apply)

☐ Automated machine (e.g., RenaClear® System)
☐ Spray device (e.g., ASSIST® header cleaner)
☐ Insertion of twist-tie or other instrument to break up clots
☐ Disassemble dialyzer to manually clean
☐ Other, specify: _____
☐ No separate header cleaning step performed

f. Is there a limit to the number of times a dialyzer is used?

☐ Yes (indicate number): _____
☐ No limit as long as dialyzer meets certain criteria (e.g., passes pressure leak test, etc.)

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E. Dialysis Policies and Practices (continued)

*23. Does your facility use hemodialysis machine Waste Handling Option (WHO) ports? ☐ Yes ☐ No

*24. Are any patients in your facility "bled onto the machine" (i.e., where blood is allowed to reach or almost reach the prime waste receptacle or WHO port)? ☐ Yes ☐ No

*25. What form of erythropoiesis stimulating agent (ESA) is generally used in your facility?

☐ Single-dose vial ☐ Multi-dose vial ☐ Pre-packaged syringe ☐ N/A

a. Is ESA from a single-dose vial or syringe administered to more than one patient? ☐ Yes ☐ No

*26. Where are medications most commonly drawn into syringes to prepare for patient administration?

☐ At the individual dialysis stations
☐ On a mobile medication cart within the treatment area
☐ At a fixed location within the patient treatment area
☐ At a fixed location removed from the patient treatment area (not a room)
☐ In a separate medication room
☐ N/A

*27. Do technicians administer any IV medications (e.g., heparin, saline)? ☐ Yes ☐ No

*28. Indicate whether your facility uses any of the following means to restrict or ensure 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	☐	☐

*29. Does your facility participate in any national or regional infection prevention 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
☐ Increasing vaccination rates
☐ Improving general infection control practices
☐ Other, specify: _____

*30. Do you follow CDC-recommended Core interventions to prevent bloodstream infections in hemodialysis patients?

☐ Yes ☐ No ☐ Don't know

*31. 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?

☐ Mupirocin ☐ Bacitracin/polymyxin (e.g., Polysporin®)
☐ Gentamicin ☐ Bacitracin/neomycin/polymyxin B (triple antibiotic)
☐ Other, specify: _____

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F. Vascular Access

For arteriovenous (AV) grafts or fistulas:

*32. Of your MAINTENANCE, NON-TRANSIENT hemodialysis patients from question 12 (12a +12b), how many received hemodialysis through each of the following access types during the first week of January?

a. AV fistula _____
b. AV graft _____
c. Tunneled central line _____
d. Nontunneled central line _____
e. Other access device (e.g., graft-catheter) _____

*33. Before prepping the area for puncture, the area is most often cleansed with:

☐ Soap and water ☐ Alcohol-based hand rub ☐ Both ☐ Neither

*34. Before puncture of a graft or fistula, the area is most often prepped with:

☐ Alcohol
☐ Chlorhexidine (e.g., Chloraprep®)
☐ Povidone-iodine (or tincture of iodine)
☐ Sodium hypochlorite solution (e.g., ExSept®)
☐ 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 swab or pad
☐ Other, specify: _____

*35. Is buttonhole cannulation performed on any fistula patients in your facility? ☐ Yes ☐ No

If Yes,

a. Indicate for what patients:

☐ Home hemodialysis ☐ In-center hemodialysis ☐ Both

b. Buttonhole cannulation is most often performed by:

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

For hemodialysis catheters:

*36. Before access of the hemodialysis catheter, the **catheter hubs** are prepped with (select the one most commonly used):

a. ☐ Alcohol
b. ☐ Chlorhexidine (e.g., Chloraprep®)
c. ☐ Povidone-iodine (or tincture of iodine)
d. ☐ Sodium hypochlorite solution (e.g., ExSept®, Alcavis)
e. ☐ Other, specify: _____
☐ Nothing

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

h. ☐ Multiuse bottle (e.g., poured onto gauze) ☐ Other, specify: _____
☐ Pre-packaged swab or pad

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F. Vascular Access (continued)

*37. When the catheter dressing is changed, the exit site (i.e., place where the catheter enters the skin) is prepped with (select 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

a. Indicate the form of antiseptic/disinfectant used at the exit site:

- ☐ Multiuse bottle (e.g., poured onto gauze) ☐ Other, specify: _____
- ☐ Pre-packaged swab or pad

*38. Are antimicrobial lock solutions used to **prevent** hemodialysis catheter infections in your facility?

☐ Yes, for all catheter patients ☐ Yes, for some catheter patients ☐ No

If Yes,

a. Indicate the lock solutions used (select all that apply):

- ☐ Sodium citrate ☐ Taurolidine
- ☐ Gentamicin ☐ Ethanol
- ☐ Vancomycin ☐ Other, specify: _____

b. Of your maintenance hemodialysis patients with a central line in Question 32 (32d + 32e), how many received prophylactic antimicrobial lock in the first week of January? _____

*39. For **hemodialysis catheters**, is antimicrobial ointment routinely applied to the exit site during dressing change? ☐ Yes ☐ No

a. If Yes, what type of ointment?

- ☐ Bacitracin/gramicidin/polymixin B (Polysporin Triple) ☐ Mupirocin
- ☐ Bacitracin/polymyxin B (e.g., Polysporin®) ☐ Povidone-iodine
- ☐ Bacitracin/neomycin/polymyxin B (triple antibiotic) ☐ Other, specify: _____

*40. Are closed connector luer access devices used on hemodialysis catheters? ☐ Yes ☐ No

If Yes,

a. Indicate what kind: ☐ Tego® ☐ Q-Stye™ ☐ Other, specify: _____

b. Indicate for what patients: ☐ Home hemodialysis ☐ In-center hemodialysis ☐ Both

*41. Are any of the following used for hemodialysis catheters (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
- ☐ None of the above

*42. Job classification of staff members who primarily perform hemodialysis catheter care (i.e., access catheters or change dressing) (select one):

☐ Nurse ☐ Technician