NHSN
NATIONAL HEALTHCARE SAFETY NETWORK

January 2024

Instructions for the Outpatient Dialysis Center Practices Survey (CDC 57.500)

A complete survey is an annual reporting requirement specified in the NHSN Dialysis Event Protocol. Users cannot create Monthly Reporting Plans or submit monthly data for May through December until a survey for that year is completed.

Print a blank survey from: http://www.cdc.gov/nhsn/forms/57.500_outpatientdialysissurv_blank.pdf

This survey is only for dialysis centers that provide In-Center Hemodialysis. If your center offers only Home dialysis services, please complete the Home Dialysis Center Practices Survey. 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.

Survey Question		Instructions for Data Collection
Facility ID #		The NHSN-assigned Facility ID will auto-populate in this field.
Survey Year		**Required**. Enter the 4-digit year that the data were collected for this facility (e.g., a 2023 survey should include data from February 2023). (format: YYYY)
ESRD Network #		**Required**. Enter the 2-digit ESRD Network number for your region.
Dialysis Center Information		
1.	What is the ownership of your dialysis center?	Required. Select the ownership of your dialysis center (Choose one option only): • Government • Not for profit • For profit
2.a	What is the location/hospital affiliation of your dialysis center?	Required. Select the location/hospital affiliation of your dialysis center (Choose one option only): • Freestanding: the dialysis center is not hospital affiliated. • Hospital based: the dialysis center is affiliated with a hospital and the building is attached to, or part of, the hospital. • Freestanding but owned by a hospital: the dialysis center is affiliated with a hospital, but the building is not attached to the hospital.
2b.	If hospital-based or hospital-owned, is your center affiliated with a teaching hospital?	Conditionally required. Select "Yes" if your center is affiliated with a hospital that has a program for medical students and post-graduate medical training (i.e., residency and/or fellowship).

		Select "No" if your center is not affiliated with a hospital that has a program for medical students and post-graduate medical training (i.e., residency and/or fellowship).
3. 3a.	Is your facility accredited by an organization other than CMS? If yes, specify (choose one)	**Required.** Select "Yes" if your facility is accredited by an organization other than CMS. Select "No" if your facility is not accredited by an organization other than CMS. Conditionally required. Indicate the organization that has accredited your facility. • National Dialysis Accreditation Commission (NDAC) • Accreditation Commission for Health Care (ACHC) • Other (specify)
4a. 4b.	What types of dialysis services does your center offer (both certified and non-certified)? (select all that apply): What patient population does your center serve?	Required. Select all dialysis service type(s) that are offered by your facility): • In-center daytime hemodialysis • In-center nocturnal hemodialysis • Home Peritoneal dialysis • In-center Peritoneal Dialysis • Home Hemodialysis (includes home, home-assisted, and NxStage®[1] patients) **Required.** Select what patient population your center serves. • Adult only • Pediatric only • Mixed: Adult and Pediatric
5.	How many in-center hemodialysis stations does your center have?	**Required**. Enter the number of in-center hemodialysis stations in your facility.
6. 6a.	Is your center part of a group or chain of dialysis centers? If yes, what is the name of the group or chain?	**Required.** Select "Yes" if your facility is part of a group or chain of dialysis centers. Select "No" if your facility is not owned by a group or chain of dialysis centers. Conditionally required. Enter the name of the dialysis facility group or chain. If owned and managed by two different groups, then indicate the managing company.

[1] Use of trade names and commercial sources is for identification only and does not imply endorsement.

7.	Do you (the person primarily responsible for collecting data for this survey) perform patient care in the dialysis center?	**Required.** Select "Yes" if the person who is primarily responsible for collecting the data for this survey performs patient care in the facility.
8. 8a.	Is there someone at your dialysis center in charge of infection control training or oversight? If yes, which best describes this person? (if >1 person in charge, select all that apply)	**Required.** Select "Yes" if there is at least one person at your dialysis center who is designated in charge of infection control training or oversight. Select "No" if no one at your dialysis center is designated in charge of infection control training or oversight. Conditionally required. Select all the description(s) that best describe the person(s) in charge of infection control in your dialysis facility.
9.	In the past year, has your clinic been cited for infection control breaches in a state/certification/recertification survey?	**Required.** Select "Yes" if your dialysis center has been cited for any infection control breaches during a state, federal, certification, and/or recertification inspection.
10. 10a.	Does your center provide dialysis services within long-term care facilities (e.g., staff-assisted dialysis in nursing homes or skilled nursing facilities; not long-term acute care hospitals)? Does your dialysis facility provide dialysis services in LTC facilities? (check all that apply)	**Required.** Select "Yes" if your dialysis center provides any dialysis services within long-term care facilities, nursing homes or skilled nursing facilities. This does not include long-term acute care hospitals. Select "No" if your center does not provide any dialysis services within long-term care facilities, nursing homes, or skilled nursing facilities. Conditionally required. Select the modalities your dialysis facility provides within LTC facilities.
11.	Which of the following staff does your facility have to ensure permanent vascular access placement and maintenance (to decrease CVC use in hemodialysis patients)?	Select all appropriate healthcare personnel that can ensure permanent vascular access placement and maintenance: • Dedicated vascular access coordinator • Nephrologist who oversees patient education and coordinates patient care related to vascular access • Relationship with or access to a surgeon skilled in access placement (or a process to refer patients to a surgeon that is skilled in access placement) • Cannulation expert • Relationship with or access to interventional nephrologists or interventional radiologist • Other, specify: _____
Isolation and Screening		
12.	Does your center have capacity to isolate patients with hepatitis B?	**Required.** Select the answer that best describes the ability of your center to isolate patients with hepatitis B.

		• Select "Yes, use hepatitis B isolation room" if a separate room exists where patients positive for hepatitis B virus infection receive hemodialysis. • Select "Yes, use hepatitis B isolation area" if a specific section of the hemodialysis clinic is designated as an area for patients positive for hepatitis B virus infection to receive hemodialysis. Select "No hepatitis B isolation" if your facility does not have the capacity to isolate patients who are positive for hepatitis B virus infection.
13.	Are patients routinely isolated or cohorted for treatment within your center for any of the following pathogens? (If yes, select all that apply)	**Required.** Select all the conditions for which patients are routinely isolated or cohorted for treatment within your facility. • If your facility would refer the patient with the condition (e.g., Active tuberculosis [TB disease]) elsewhere for dialysis, do not select that condition on the survey. • If additional criteria are used to isolate some positive patients (e.g., active diarrhea, draining wound), but not all, do not select this condition for the survey. Select "No - None" if none of the conditions listed are routinely isolated or cohorted for treatment within your facility.
14.	In the past year, where have you dialyzed patients with SARS COV-2 infections? (Select all that apply):	**Required.** Select all applicable areas within your dialysis center where SARS-CoV-2 positive patients have been dialyzed: • Isolation room • Covid shift • Covid Unit • Separate area on treatment floor while other non-COVID patients are dialyzed • Not applicable, if no SARS-CoV-2 positive patients were dialyzed at your clinic in the past year
15. 15a. 15b.	Are patients routinely assessed for conditions that might warrant additional infection control precautions, such as infected wounds with drainage, fecal incontinence or diarrhea? If yes, when does this assessment most often occur? (Select one) Do you isolate or cohort these patients?	**Required.** Select "Yes" if patients are routinely assessed for conditions that might warrant additional infection control precautions. Select "No" if patients are not routinely assessed for conditions that warrant additional infection control precautions. Conditionally required. Indicate when the assessment of patients occurs.

		Conditionally required. Select "Yes" if these patients are isolated or cohorted. Select "No" if these patients are not isolated or cohorted.
16. 16a.	Does your center routinely screen patients for latent tuberculosis infection (LTBI) on admission to your center? If yes, what method is used to screen? (Select all that apply)	**Required**. Select "Yes" if your center routinely screens patients for latent tuberculosis infection (LTBI) upon admission. Select "No" if patients are not routinely screened for TB upon admission. Conditionally required for facilities that routinely screen patients for LTBI. Indicate all methods used to screen patients for latent tuberculosis infections. • Tuberculin Skin Test (TST) • Blood Test • Other (specify)
17.	Does your facility have an airborne infection isolation room (AIIR) to isolate patients infected with pathogens that are transmitted through the airborne route (for example, active tuberculosis)?	**Required.** Select "Yes" if your dialysis facility has an airborne infection isolation room (AIIR) to isolate patients infected with pathogens that are transmitted through the airborne route. Select "No" if your dialysis facility does not have an airborne infection isolation room (AIIR).
Patient Records and Surveillance		
18.	Does your center maintain records of the **station** where each patient received their hemodialysis treatment for every treatment session?	**Required.** Select "Yes" if your facility maintains written or electronic records of patients' hemodialysis station assignment. Select "No" if these records are not maintained.
19.	Does your center maintain records of the **machine** used for each patient's hemodialysis treatment for every treatment session?	**Required.** Select "Yes" if your facility maintains written or electronic records of patients' hemodialysis machine assignment. Select "No" if these records are not maintained.
20.	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?	**Required.** Following a hospitalization, indicate the frequency with which your facility can determine whether a bloodstream infection contributed to the patient's hospital admission. Select "N/A – not pursued" only if your facility does not try to determine the cause of hospitalizations.
21.	How often is your center able to obtain a patient's microbiology lab records from a hospitalization?	**Required.** Following a hospitalization, indicate the frequency with which your facility is able to obtain the patient's hospital microbiology lab records. Select "N/A – not pursued" only if your facility does not routinely request microbiology lab records after a patient is hospitalized.
Patient Census		

22.	Was your center operational during the first week of February (2/1 through 2/7)?	**Required.** Select "Yes" if your facility was open for hemodialysis treatment during the first week of February (Feb. 1 – Feb. 7) of the survey year. Select "No" if your facility was closed for hemodialysis treatment during the first week of February of the survey year. • If you select "No," proceed to answer subsequent questions about your facility's policies since the first week of February and enter zeros for quantitative questions (if applicable).
23. 23a. 23b. 23c.	How many MAINTENANCE, NON-TRANSIENT ESRD and AKI dialysis PATIENTS were assigned to your center during the first week of February? In-center hemodialysis Home hemodialysis Peritoneal dialysis	**Required.** Indicate the total number of all the maintenance, non-transient, ESRD and AKI dialysis patients assigned to your facility during the first week of February (Feb. 1 – Feb. 7) of the survey year (include in-center hemodialysis, home hemodialysis, and peritoneal dialysis patients). The sum of 24.a., 24.b., and 24.c., must be equal to the answer to question 24. Conditionally required. Of the patients specified in question 24, indicate how many underwent in-center hemodialysis during the first week of February. Conditionally required. Of the patients specified in question 24, indicate how many underwent home hemodialysis during the first week of February. Include home, long-term care facilities or nursing home, home-assisted, and NxStage®[2] patients. Conditionally required. Of the patients specified in question 24, indicate how many underwent peritoneal dialysis during the first week of February.
24.	Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Race:	**Optional.** Specify one or more of the choices below to identify the individual's race. NOTE: Collecting race and ethnicity is important for understanding trends in the COVID-19 pandemic and ensuring the wellbeing of racial and ethnic minority groups. • American Indian/Alaska Native • Asian • Black or African American • Native Hawaiian/Other Pacific Islander • White • More than one Race • Declined to respond • Unknown

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		This data should be based upon the individual respondent's self-identification with regards to race. If the patient is a poor historian, solicit information from a reliable family member. NOTE: Hispanic or Latino is not a race. A person may be of any race while being Hispanic or Latino
25.	Based on the number of patients that treated in the first week of February (2/1 through 2/7), please indicate the number of patients per Ethnic group:	**Optional.** Specify if the individual is either Hispanic or Latino, or Not Hispanic or Not Latino. Hispanic or Latino is defined as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.* The patient should always be asked to identify their race and ethnicity. If the patient is not a good historian, then check with a reliable family member. NOTE: Collecting race and ethnicity is important for understanding trends in the COVID-19 pandemic and ensuring the wellbeing of racial and ethnic minority groups. However, if after all attempts it is not possible to obtain ethnicity information, the appropriate response below, may be chosen: • Declined to respond • Unknown * https://www.census.gov/topics/population/hispanic-origin/about.html
Staff		
26.	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: Of these, how many were in each of the following categories?	**Required**. Indicate the total number of patient care staff (including full time, part time, and affiliated with) who worked in your center during the first week of February (Feb. 1 – Feb. 7) of the survey year. • Count each person as 1, even if they work part-time. • If a person works at more than one facility, they are counted as 1 at each facility. • Include physicians who see patients in the facility. • Include patient care staff who are normally present during the year, but were absent this week due to vacation or other leave. • Include per diem staff only if they are consistently part of facility staffing. • If your facility was not operational during the 1st week of February, enter 0. Conditionally required. Of the total number of patient care staff specified in question 27, indicate the number per occupational category. The sum of the occupational categories in questions 27a. – 27h. must equal the number of patient care staff indicated in question 27. • Nurse/nurse assistant • Dialysis patient-care technician

		• Dialysis biomedical technician • Social worker • Dietitian • Physicians/physician assistant • Nurse practitioner • Other
27. 27a. 27b.	Of the patient care staff members counted in question 27, how many received: A completed series of hepatitis B vaccine (ever)? The influenza (flu) vaccine for the current/most recent flu season?	Conditionally required. Of the patient care staff members counted in question 27, indicate how many have ever received: Completed a series of hepatitis B vaccine. • Do not count patients who are in the process of completing the hepatitis B vaccine series. • The number of doses required to complete a series will vary depending on which vaccine was used. • Currently recommended series are described here [Hepatitis B Questions and Answers for Health Professionals | CDC](#). • Recommended vaccine series may change and dose and volume recommended may be different for pediatric and adult patients. • If patients were not vaccinated at your facility, include patients if they report they received the completed series and test positive for HB surface antibody or have documentation of completed series. Indicate how many received the flu vaccine for the current/most recent flu season. • This refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2015, count flu vaccinations for the 2014-2015 flu season. • Include patient care staff members who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If none of the patient care staff members have received the influenza vaccine for the current/most recent flu season, enter 0.
28.	Does your center use standing orders to allow nurses to administer any of the vaccines mentioned above to patients without a specific physician order?	**Required.** Select "Yes" if your facility uses standing orders to allow nurses to administer some or all the vaccines mentioned below to patients without a specific physician order. These vaccines include: • Hepatitis B vaccine

		• Influenza vaccine for the current/most recent flu season • Pneumococcal vaccine Select "No" if there are no standing orders for any of the mentioned vaccines.
29. 29a.	Does your center have a respiratory program for annual fit testing on your healthcare personnel? Which staff do you fit test? (Select all that apply)	**Required.** Select "Yes" if your dialysis center has a respiratory program for healthcare personnel annual fit testing. Select "No" if your dialysis center does not have such a respiratory program. Conditionally required. If "Yes" is selected for #30, please indicate which staff members are fit tested: • Nurse/Nurse Assistant • Dietitian • Dialysis Patient-Care Technician • Physicians/Physician Assistant • Dialysis Biomedical Technician • Nurse Practitioner • Social Worker • Other:
29b.	How many patient care staff did your center have fit tested this year?	Conditionally required. If "Yes" is selected for #30, please indicate the number of patient care staff members that were fit tested this year.
In Center Hemodialysis Patients		
30.	Number of maintenance, non-transient ESRD and AKI In Center Hemodialysis patients that were assigned to your center during the first week of February (2/1 through 2/7)	Auto-populated. The number of ESRD and AKI In-Center Hemodialysis patients entered in #24a will display.
31.	Of the maintenance, non-transient ESRD and AKI **In-Center Hemodialysis** patients in question #31, how many received hemodialysis through each of the following access types during the first week of February (2/1 through 2/7)?	**Required**. Indicate the number of maintenance, non-transient ESRD and AKI In-Center Hemodialysis patients that received hemodialysis through each of the following accesses during the first week of February. Count each patient only once. a. AV fistula b. AV graft c. Tunneled central line d. Non-tunneled central line e. Other vascular access device (e.g., HeRO®)
32.	Does your dialysis facility perform buttonhole cannulation for **In-Center Hemodialysis** patients?	**Required.** Buttonhole cannulation is a technique where a patient's fistula is regularly accessed by inserting a blunt needle (cannula) into the fistula at the same location each time using an established track. Select "Yes" if your center performs buttonhole cannulation.

		Select "No" if your center does not perform buttonhole cannulation.
32a.	Of the AV fistula patients in question #32a, how many had buttonhole cannulation?	Conditionally required. Indicate how many in-center hemodialysis patients from question 32a had buttonhole cannulation.
32b.i.	When buttonhole cannulation is performed for In-Center Hemodialysis patients: Who most often performs it?	Conditionally required. Indicate who most often performs buttonhole cannulation for in-center hemodialysis patients.
32.b.ii.	Before buttonhole cannulation, what is the buttonhole site most often prepped with? (select the one most commonly used)	Conditionally required. Indicate which antiseptic/disinfectant is most often used to prep the buttonhole sites. Select "Nothing" if an antiseptic/disinfectant is not used to prep the buttonhole site.
32.b.iii.	Is antimicrobial ointment (e.g., mupirocin) routinely used at buttonhole cannulation sites to **prevent** infection?	Conditionally required. Select "Yes" if antimicrobial ointment is applied at the buttonhole cannulation site to prevent infections. Select "No" if antimicrobial ointment is not used at the buttonhole cannulation site to prevent infections
33.	Which type of pneumococcal vaccine does your center offer to In Center Hemodialysis patients?	**Required.** Select the most commonly used type of pneumococcal vaccine offered to your facility's patients (choose one): • New Conjugate (PCV20) only • New Conjugate (PCV15) and Polysaccharide (PPSV23) • Both New Conjugate (Either PCV20 or PCV15) and Polysaccharide (PPSV23)—in case there are facilities that decided to keep all options available • Other (please specify) • Neither offered Select "Neither offered" if the pneumococcal vaccine is not offered.
34.	Of the maintenance, non-transient ESRD and AKI In-Center Hemodialysis patients counted in question 31, how many received:	Conditionally required. Of the total number of maintenance, non-transient ESRD and AKI *In Center hemodialysis* patients indicated in question 31, indicate: (Beginning 2021, this question will auto-populate with "0" if 24a equals "0")
34a.	A completed series of hepatitis B vaccine (ever)?	Indicate how many patients have ever completed a series of hepatitis B vaccine. • Do not count patients who are in the process of completing the hepatitis B vaccine series.

		• The number of doses required to complete a series will vary depending on which vaccine was used. • Currently recommended series are described here Hepatitis B Questions and Answers for Health Professionals | CDC. • Recommended vaccine series may change and dose and volume recommended may be different for pediatric and adult patients. • If patients were not vaccinated at your facility, include patients if they report they received the completed series and test positive for HB surface antibody or have documentation of completed series.
34b.	The influenza (flu) vaccine for the current/most recent flu season?	Indicate how many received the influenza (flu) vaccine for this flu season (September or later). • This question refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2023, count flu vaccinations for the 2022-2023 flu season. • Include patients who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If no patients received the influenza vaccine for the current/most recent flu season, enter 0.
34c.	At least one dose of pneumococcal vaccine (ever)?	Indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. • If no patients received the pneumococcal vaccine ever, enter 0. • Documentation of a pneumococcal vaccine is required to include patients in this field
35.	Of the MAINTENANCE, NON-TRANSIENT ESRD and AKI In-Center hemodialysis PATIENTS from question 31:	Of the maintenance, non-transient ESRD and AKI in-center hemodialysis patients specified in question:
35a.	How many were hepatitis B surface **ANTIGEN** (HBsAg) positive in the first week of February?	Conditionally required. Indicate how many were hepatitis B virus surface antigen (i.e., HBsAg) positive in the first week of February (Feb. 1 – Feb. 8). This is a measure of prevalence of hepatitis B virus infection among patients in your facility during this period.
35a.i.	Of these patients who were hepatitis B surface **ANTIGEN** (HBsAg) positive in the first week of February, how many were	Conditionally required. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 31, indicate how many were hepatitis B virus surface antigen (i.e., HBsAg)

	positive when first admitted to your center?	positive when they were first admitted to your facility (i.e., they had hepatitis B virus infection upon admission). This is a measure of prevalence of hepatitis B virus infection among your incoming patients.
35b.	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*)?	Conditionally required. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 31, indicate how many converted from hepatitis B virus surface antigen (i.e., HBsAg), negative to positive, during the 12 months prior to February (i.e., they acquired HBV infection in the past year). Do not include patients who were antigen positive before they were first dialyzed in your center (i.e., patients specified in question 31a.i). This is a measure of annual incidence of hepatitis B virus infection among patients in your facility. *Do not include patients who were antigen positive before they were first dialyzed in your center.*
36.	In the past year, has your center had ≥1 In Center Hemodialysis patient who reverse seroconverted (i.e. had evidence of resolved hepatitis B infection followed by reappearance of hepatitis B surface antigen)?	**Required.** Select "Yes" if 1 or more hemodialysis patients had evidence of resolved hepatitis B infection followed by reappearance of hepatitis B surface antigen. Select "No" if none of your center's patients reverse seroconverted.
37.	Does your center routinely screen **<u>In-Center Hemodialysis</u>** patients for Hepatitis C antibody (anti-HCV) on admission to your center? *(Note: This is NOT hepatitis B core antibody)*	**Required.** Select "Yes" if your facility screens hemodialysis patients for hepatitis C antibody (anti-HCV) upon admission. Select "No" if your facility does not screen hemodialysis patients for hepatitis C antibody (anti-HCV) upon admission.
38.	Does your center routinely screen hemodialysis patients for hepatitis C antibody (anti-HCV) at any other time?	**Required.** Select "Yes" if your facility screens hemodialysis patients for hepatitis C antibody (anti-HCV) at any time other than upon admission. Select "No" if your facility does not screen hemodialysis patients for hepatitis C antibody (anti-HCV) at any other times than upon admission. Select "No" if hepatitis C testing is diagnostic only.
38a.	If yes, how frequently?	Conditionally required. Indicate the frequency of non-admission hepatitis C antibody (anti-HCV) screening. • Twice annually: screening is two times per year, after admission. • Annually: if screening is once per year, any time after admission. • Otherwise, select "Other" and specify the frequency of post-admission HCV screening.

39.	Of the MAINTENANCE, NON-TRANSIENT ESRD and AKI **In-Center Hemodialysis** patients in question #31	Of the maintenance, non-transient ESRD and AKI in-center hemodialysis patients specified in question 31: • If your facility does not screen for hepatitis C antibody, respond by counting patients with records of known history of HCV infection. This is a measure of prevalence of hepatitis C virus infection among your patients.
39a.	How many were hepatitis C antibody positive in the first week of February?	Conditionally required. Indicate how many were hepatitis C virus antibody (i.e., anti-HCV) positive in the first week of February (the first seven calendar days of the month).
39a.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?	Conditionally required. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 24a, indicate how many were hepatitis C antibody (anti-HCV) positive when they were first admitted to your facility (i.e., they had hepatitis C virus infection upon admission).
39b.	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.	Conditionally required. Of the maintenance, non-transient, in-center hemodialysis patients specified in question 24a, indicate how many converted from hepatitis C antibody (i.e., anti-HCV) negative to positive during the 12 months prior to February (i.e., they acquired HCV infection in the past year). Do not include patients who were anti-HCV positive before they were first dialyzed in your center.
Peritoneal Dialysis Patients		
40.	Number of maintenance, non-transient ESRD and AKI **Peritoneal Dialysis** patients that were assigned to your center during the first week of February (2/1 through 2/7)	Auto-populated. The number of ESRD and AKI Peritoneal Dialysis patients entered in #24c will display.
41.	Which type of pneumococcal vaccine does your center offer to **Peritoneal Dialysis** patients? (choose one)	**Required.** Select the most commonly used type of pneumococcal vaccine offered to your facility's patients (choose one): • New Conjugate (PCV20) only • New Conjugate (PCV15) and Polysaccharide (PPSV23) • Both New Conjugate (Either PCV20 or PCV15) and Polysaccharide (PPSV23)—in case there are facilities that decided to keep all options available • Other (please specify) • Neither offered Select "Neither offered" if the pneumococcal vaccine is not offered.

42.	Of the **Peritoneal Dialysis** patients in question #41, how many received:	Conditionally required. Of the total number of maintenance, non-transient ESRD and AKI *Peritoneal Dialysis* patients indicated in question 41, indicate: (Beginning 2021, this question will auto-populate with "0" if 24c equals "0")
42a.	A completed series of hepatitis B vaccine (ever)?	Indicate how many patients have ever completed a series of hepatitis B vaccine. • Do not count patients who are in the process of completing the hepatitis B vaccine series. • The number of doses required to complete a series will vary depending on which vaccine was used. • Currently recommended series are described here Hepatitis B Questions and Answers for Health Professionals | CDC. • Recommended vaccine series may change and dose and volume recommended may be different for pediatric and adult patients. • If patients were not vaccinated at your facility, include patients if they report they received the completed series and test positive for HB surface antibody or have documentation of completed series.
42b.	The influenza (flu) vaccine for the current/most recent flu season?	Indicate how many received the influenza (flu) vaccine for this flu season (September or later). • This question refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2023, count flu vaccinations for the 2022-2023 flu season. • Include patients who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If no patients received the influenza vaccine for the current/most recent flu season, enter 0.
42c.	At least one dose of pneumococcal vaccine (ever)?	Indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. • If no patients received the pneumococcal vaccine ever, enter 0. • Documentation of a pneumococcal vaccine is required to include patients in this field
43.	Which of the following infections in your **Peritoneal Dialysis** patients does your	**Required.** Select all infections that are routinely tracked among peritoneal dialysis patients in your center

	center routinely track? (Select all that apply)	
44. 44a.	For **Peritoneal Dialysis** catheters, is antimicrobial ointment routinely applied to the exit site during dressing change? If yes, what type of ointment is most commonly used? (select one)	**Required.** Select "Yes" if antimicrobial ointment is routinely applied to peritoneal dialysis catheter exit sites during dressing changes. Select "No" if antimicrobial ointment is not routinely applied to the peritoneal dialysis catheter exit site during dressing changes. Conditionally required if antimicrobial ointment is routinely used. Select one antimicrobial ointment that is most commonly applied to the peritoneal dialysis catheter exit site during dressing changes.
Home Hemodialysis Patients		
45.	Number of maintenance, non-transient ESRD and AKI **Home Hemodialysis** patients that were assigned to your center during the first week of February (2/1 through 2/7)	Auto-populated. The number of ESRD and AKI Home Hemodialysis patients entered in #24b will display.
46.	Of the **Home Hemodialysis** patients counted in question 46, how many received hemodialysis through each of the following access types during the first week of February (2/1 through 2/7)?	Conditionally required**.** Of the total number of maintenance, non-transient ESRD and AKI *home hemodialysis* patients indicated in questions 46, indicate how many patients received hemodialysis through each access type during the first week of February (the first seven calendar days of the month). • Access types include: AV fistula, AV graft, Tunneled central line, Nontunneled central line, and other vascular access device (e.g., HeRO®) • Note: this question requires a different counting process than the Denominators for Outpatient Dialysis form: count all accesses that were used for hemodialysis during the week.
47.	Does your in-center hemodialysis facility perform buttonhole cannulation for Home Hemodialysis patients?	**Required.** Buttonhole cannulation is a technique where a patient's fistula is regularly accessed by inserting a blunt needle (cannula) into the fistula at the same location each time using an established track. Select "Yes" if your center performs buttonhole cannulation for home hemodialysis patients. Select "No" if your center does not perform buttonhole cannulation for home hemodialysis patients.

47a.	Of the AV fistula patients from question 47a, how many had buttonhole cannulation?	Conditionally required. Indicate how many *home hemodialysis* patients from question 47a had buttonhole cannulation.
47b.i.	When buttonhole cannulation is performed for home hemodialysis patients. Who most often performs it?	Conditionally required. Indicate who most often performs buttonhole cannulation for *home hemodialysis* patients.
47b.ii.	Before cannulation, what is the buttonhole site most often prepped with? (select the one most commonly used)	Conditionally required. Indicate which antiseptic/disinfectant is most often used to prep the buttonhole sites. Select "Nothing" if an antiseptic/disinfectant is not used to prep the buttonhole site.
47b.iii	Is antimicrobial ointment (e.g., mupirocin) routinely used at buttonhole cannulation sites to **prevent** infection?	Conditionally required. Select "Yes" if antimicrobial ointment is applied at the buttonhole cannulation site to prevent infections. Select "No" if antimicrobial ointment is not used at the buttonhole cannulation site to prevent infections.
48.	Which type of pneumococcal vaccine does your center offer to Home Hemodialysis patients? (choose one)	**Required.** Select the most commonly used type of pneumococcal vaccine offered to your facility's patients (choose one): • New Conjugate (PCV20) only • New Conjugate (PCV15) and Polysaccharide (PPSV23) • Both New Conjugate (Either PCV20 or PCV15) and Polysaccharide (PPSV23)—in case there are facilities that decided to keep all options available • Other (please specify) • Neither offered Select "Neither offered" if the pneumococcal vaccine is not offered.
49.	Of the **Home Hemodialysis** patients in question #41, how many received:	Conditionally required. Of the total number of maintenance, non-transient *home hemodialysis* patients indicated in question 41: (Beginning 2021, this question will auto-populate with "0" if 24b equals "0")
49a.	A completed series of hepatitis B vaccine (ever)?	Indicate how many ever received a completed series of hepatitis B vaccine. • Do not count patients who are in the process of completing the hepatitis B vaccine series. • The number of doses required to complete a series will vary depending on which vaccine was used.

		• Currently recommended series are described here Hepatitis B Questions and Answers for Health Professionals | CDC. • Recommended vaccine series may change and dose and volume recommended may be different for pediatric and adult patients. • If patients were not vaccinated at your facility, include patients if they report they received the completed series and test positive for HB surface antibody or have documentation of completed series.
49b.	The influenza (flu) vaccine for the current/most recent flu season?	Indicate how many received the influenza (flu) vaccine for this flu season (September or later). • This question refers to the flu season that began in the year preceding the survey year. For example, if the survey year is 2023, count flu vaccinations for the 2022-2023 flu season. • Include patients who report having received a flu vaccination for this season (or for whom there is documentation) even if they were not vaccinated at your facility. • If patients received the influenza vaccine for the current/most recent flu season, enter 0.
49c.	At least one dose of pneumococcal vaccine (ever)?	Indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. • If no patients received the pneumococcal vaccine ever, enter 0. • Documentation of a pneumococcal vaccine is required to include patients in this field
50.	Which of the following events in your home hemodialysis patients does your center routinely track?	**Required.** Select all infections that are routinely tracked among home hemodialysis patients in your center.
Priming Practices		
51.	Does your center use hemodialysis machine Waste Handling Option (WHO) ports?	**Required.** A waste handling option (WHO) port is a feature of some hemodialysis machines that is designed to dispose of any saline that is flushed through the dialyzer before the machine is used for a patient. Select "Yes" if your facility uses WHO ports. Select "No" if the hemodialysis machines at your facility do not have WHO ports or if WHO ports are present, but not used.
52.	Are any patients in your center "bled onto the machine" (i.e., where blood is allowed to reach	**Required.** Select "Yes" if any patients in your facility are "bled onto the hemodialysis machine," a process where blood is

	or almost reach the prime waste receptacle or WHO port)?	allowed to reach or almost reach the prime waste receptacle or WHO port. Select "No" if patients are not bled onto their machines.
Injection Practices		
53.	What form of erythropoiesis stimulating agent (ESA) medications are most often used in your center?	**Required.** Select one form of erythropoiesis stimulating agent (ESA) that is most often used in your facility. • "Single-dose" (also known as "single-use") • Please refer to the ESA's manufacturer label to determine if the product most frequently used in your facility is labeled "single-dose" or "multi-dose." If ESA is not used, select "N/A."
54.	Where are medications <u>most commonly</u> drawn into syringes to prepare for patient administration?	**Required.** Select one location where medications are most commonly drawn into syringes to prepare for patient administration.
55.	Do technicians administer any IV medications or infusates (e.g., heparin, saline) in your center?	**Required.** Select "Yes" if technicians ever administer any IV medications or infusates, such as heparin or saline, to patients. Select "No" if technicians never administer IV medications to patients.
56.	What form of **saline flush** is most commonly used?	**Required.** Select the one form of saline flush most commonly used in your facility during catheter care and throughout treatment. If the most common form of saline flush is not listed, select "Other" and enter in the type of saline flush most commonly used in your facility.
Antibiotic Use		
57.	Does your center use the following means to restrict or ensure appropriate antibiotic use?	**Required.** Select "Yes" only for those practices that have been implemented for the purpose of "appropriate antibiotic use." Select "No" If antibiotics are restricted, but for another purpose (e.g., cost management), or if there are no antimicrobial restrictions in your center.
57a.	Have a written policy on antibiotic use	Have a written policy on antibiotic use: any written plan to guide and determine the present and future decisions about appropriate antibiotic use.
57b.	Formulary restrictions	Formulary restrictions: the existence of rules that limit the use of certain types of antimicrobials.
57c.	Antibiotic use approval process	Antibiotic use approval process: a mechanism exists to ensure specific criteria are met before antibiotics are administered.
57d.	Automatic stop orders for antibiotics	Automatic stop orders for antibiotics: in the absence of a physician's review and order for continuation, antibiotics are automatically discontinued after a specified period.

58.	In your center, how often are antibiotics administered for a suspected bloodstream infection before blood cultures are drawn (or without performing blood cultures)?	**Required.** Indicate the frequency with which antibiotics are administered to a patient for a suspected bloodstream infection before blood cultures are drawn.
59. 59a. 59b.	Does your center routinely test the following whenever a patient has a pyrogenic reaction? Patient blood culture Dialysate from the patient's dialysis machine	**Required.** Select "Yes" only if your facility routinely tests a patient's blood or dialysate for both culture and endotoxin whenever a patient has a pyrogenic reaction. Select "No" if testing blood for both culture and endotoxin is not routine practice. If there has never been a pyrogenic reaction among your patients, respond based on facility policy.
Prevention Activities		
60. 60a. 60b.	Has your center participated in any national or regional infection prevention-related initiatives in the past year? If yes, what is the primary focus of the initiative(s)? (if >1 initiative, select all that apply) If yes, is your center actively participating in any of the following prevention initiatives (select all that apply):	**Required.** Select "Yes" if your center participates in any national or regional infection prevention initiatives. This includes infection prevention initiatives directed by your ESRD Network. Select "No" if your center has not participated in any national or regional infection prevention-related initiatives. Conditionally required. Indicate the primary focus of the initiative(s). If involved in more than one initiative, indicate the primary focus of each initiative. Conditionally required. Indicate if your center is actively participating in any of the listed initiatives. • Participation at the center-level indicates staff and patients at your center are actively using CDC interventions based on your center's desire to participate. • Participation at the corporate/organization-level indicates your center is actively using CDC interventions because of a requirement of your corporation or your ESRD Network, for example.
61a. 61b.	What education do you provide to patients in your center when they start dialysis? (check all that apply): What education do you provide to your patients regularly (at least annually) (check all that apply)	**Required.** Select all educational trainings that are provided to patients when they start dialysis. **Required.** Select all educational trainings provided to patients at least annually.
62.	Which of the following CDC Core Interventions does your center apply for prevention of blood	**Required.** Select all CDC Core Interventions that your dialysis center utilizes to prevent bloodstream infections.

	stream infections? (Check all that apply)	
63.	Does your center provide training for staff on infection prevention and control at least once annually?	**Required.** Select "Yes" only if your facility routinely provides training for staff on infection prevention and control at least once annually. Select "No" if your facility does not offer staff training on infection prevention and control, or if it is not at least once annually.
64.	Does your center perform staff knowledge assessments for infection prevention and control annually (or more frequently)?	**Required.** Select "Yes" only if your facility performs staff knowledge assessments for infection prevention and control at least once annually. Select "No" if your facility does not perform staff knowledge assessments on infection prevention and control, or if it is not performed at least once annually.
65.	Does your center perform hand hygiene audits of staff monthly (or more frequently)?	**Required.** Select "Yes" if your facility performs hand hygiene audits monthly, or more frequently. Select "No" if your facility does not perform hand hygiene audits, or if the audits are performed less often than monthly.
66.	Does your center perform observations of staff vascular access care and catheter accessing practices quarterly (or more frequently)?	**Required.** Select "Yes" if your facility performs vascular access care observations and catheter access observations quarterly, or more frequently. Select "No" if your facility does not perform vascular access care observations and catheter access observations, or if the observations are performed less often than quarterly.
67.	Does your center perform staff competency assessments for vascular access care and catheter accessing annually (or more frequently)?	**Required.** Select "Yes" if your facility performs staff competency assessments for vascular access care and catheter accessing annually, or more frequently. Select "No" if your facility does not perform staff competency assessments for vascular access care and catheter accessing, or if the assessments are performed less often than yearly.
Arteriovenous (AV) Fistulas or Grafts		
68.	Before prepping the fistula or graft site for cannulation, what is the access site most often cleansed with (either by patients or staff upon entry to the clinic)?	**Required.** Indicate which antiseptic/disinfectant is most often used to clean the graft/fistula site for cannulation. (select one) Select "Other" if the cleanser used is not listed and specify the cleanser.

		Select "Nothing" if a cleanser is not used to cleanse the fistula or graft site for cannulation.
69.	Before cannulation of a fistula or graft, what is the skin most often prepped with? (select one)	**Required.** Indicate which antiseptic/disinfectant is most often used to prep the graft or fistula site for cannulation (select one). Select "Other" if the antiseptic/disinfectant used is not listed and specify the antiseptic/disinfectant. Select "Nothing" if an antiseptic/disinfectant is not used to prep the fistula or graft site for cannulation.
Hemodialysis Catheters		
70.	Before accessing the hemodialysis catheter, what are the catheter hubs most commonly prepped with? (select one)	**Required.** Indicate which antiseptic/disinfectant is most often used to prep the catheter hubs prior to accessing hemodialysis catheters. Select "Other" if the antiseptic/disinfectant used is not listed and specify the antiseptic/disinfectant. Select "Nothing" if an antiseptic/disinfectant is not used to prep the catheter hubs.
71.	Are hemodialysis 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)?	**Required.** Select "Yes" if catheter hubs are routinely scrubbed after the cap is removed, but before the catheter is accessed. Select "No" if scrubbing catheter hubs is not routine practice or if the process is not appropriately implemented.
72.	When the hemodialysis catheter dressing is changed, what is the exit site (i.e., place where the catheter enters the skin) most commonly prepped with? (select one)	**Required.** Indicate which antiseptic/disinfectant is most often used to prep the exit site. Select "Other" if the antiseptic/disinfectant used is not listed and specify the antiseptic/disinfectant. Select "Nothing" if an antiseptic/disinfectant is not used to prep the exit site.
73.	For hemodialysis catheters, is antimicrobial ointment routinely applied to the exit site during dressing change?	**Required.** Select "Yes" if antimicrobial ointment is routinely applied to the hemodialysis catheter exit site during dressing changes. Select "No" if antimicrobial ointment is not routinely applied to the hemodialysis catheter exit site during dressing changes. Select "N/A" if your center uses chlorhexidine-impregnated dressings.
73a.	If yes, what type of ointment is most commonly used? (select one)	Conditionally required. Select one antimicrobial ointment that is most commonly applied to the hemodialysis catheter exit site during dressing changes. Select "Other" and specify if a different type of antimicrobial ointment is used.

74.	Who most often accesses hemodialysis catheters for treatment in your center? (select one)	**Required.** Select one job classification that describes the staff members who most often accesses hemodialysis catheters for treatment in your center. Select "Other" and specify the job classification if the staff members who most often access hemodialysis catheters in your center are not nurses or technicians.
75.	Who most often performs hemodialysis exit site care in your center? (select one)	**Required.** Select one job classification that describes the staff members who most often performs hemodialysis exit site care in your center. Select "Other" and specify the job classification if the staff members who most often perform hemodialysis exit site care in your center are not nurses or technicians.
76. 76a.	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections in your center? If yes, which lock solution is most commonly used? (select one)	**Required.** Indicate whether antimicrobial lock solutions are used to prevent hemodialysis catheter infections for all catheter patients in your facility, for some catheter patients in your facility, or for none of the catheter patients in your facility. Conditionally required. Select one type of antimicrobial lock solution that is most commonly used in your facility. • Sodium citrate • Gentamycin • Vancomycin • Taurolidine • Ethanol • Multi-component lock solution or other
77. 77a.	Are needleless closed connector devices (e.g., Tego®, Q-Syte™) used on hemodialysis catheters in your center? If yes, for which patients:	**Required.** Select "Yes" if closed connector devices are used on hemodialysis catheters in your facility. Select "No" if closed connector devices are not used on hemodialysis catheters in your facility. Conditionally required. Indicate for which patients they are used (i.e. home hemodialysis patients, in-center hemodialysis patients, or both).
78.	Are any of the following routinely used for hemodialysis catheters in your center? (select all that apply)	**Required.** Select all of the applicable antimicrobial/antiseptic products that are routinely used for hemodialysis catheters in your facility (i.e., used more frequently than 50% of the time)
79.	Does your center provide hemodialysis catheter patients with supplies to allow for changing catheter dressings outside the dialysis center?	**Required.** Select "Yes, routinely" if your center has a policy to provide dressing change supplies to all catheter patients to use outside the dialysis center. Note: Select this option if your facility does not have a written policy that does not specifically exclude any catheter patients from receiving these supplies.

		Select "Yes, only in certain circumstances" if your facility has a policy to only provide dressing change supplies to a select group of catheter patients. Select "No" if your facility does not have a policy to provide dressing change supplies to catheter patients.
80a.	Does your center educate patients with hemodialysis catheters on how to shower with the catheter? (select the best response)	**Required.** Select "Yes, routinely" if your facility has a policy to provide patient education on how to shower with the catheter to all catheter patients. Select "Yes, only in certain circumstances" if your facility has a policy that restricts the patient education of how to shower with the catheters to a select group of catheter patients. Select "No" if your facility does not have a policy to educate patients with catheters on how to shower.
80b.	Does your center provide hemodialysis catheter patients with a protective catheter cover (e.g., Shower Shield®, Cath Dry™) to allow them to shower?	**Required.** Select "Yes, routinely" if your facility has a policy to provide protective catheter covers to all catheter patients. Select "Yes, only in certain circumstances" if your facility has a policy that restricts the provision of catheter covers to a select group of catheter patients. Select "No" if your facility has a policy to not provide catheter covers to patients.
Comments		Optional. Use this field to add any additional information about the dialysis survey necessary to interpret your responses. If the character limit is inadequate, please email your comments to the NHSN Helpdesk at nhsn@cdc.gov.