

Instructions for Completion of the Home Dialysis Center Practice Survey (CDC 57.507)

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: https://www.cdc.gov/nhsn/forms/57.507_dialhomesurv_blank.pdf

This survey is only for dialysis centers that do not offer in-center hemodialysis. If your center offers in-center hemodialysis, please complete the Outpatient Dialysis Center Practices Survey in the NHSN Dialysis Component. 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 2020 survey should include data from February 2020). (format: YYYY)
ESRD Network #	Required. Enter the 2-digit ESRD Network number for your region.

A. Dialysis Center Information

A.1.	General	
1.	What is the ownership of your dialysis center?	Required. Select the ownership of your dialysis center (Choose one option only): <ul style="list-style-type: none"> • Government • Not for profit • For profit •
2.	What is the location/hospital affiliation of your dialysis center?	Required. Select the location/hospital affiliation of your dialysis center (Choose one option only): <ul style="list-style-type: none"> ○ <u>Freestanding</u>: the dialysis center is not hospital affiliated. ○ <u>Hospital based</u>: the dialysis center is affiliated with a hospital and the building is attached to, or part of, the hospital. ○ <u>Freestanding but owned by a hospital</u>: the dialysis center is affiliated with a hospital, but the building is not attached to the hospital.

Survey Question		Instructions for Data Collection
3.	Is your facility accredited by an organization other than CMS?	Required. Select “Yes” if your facility is accredited by an organization other than CMS. Select “No” if your facility is not accredited by any organization other than CMS.
a.	If yes, specify (choose one)	Conditionally required. Indicate the organization that has accredited your organization. <ul style="list-style-type: none"> • Joint Commission • National Dialysis Accreditation Commission (NDAC) • Accreditation Commission for Health Care (ACHC) • Other (specify)
4. a.	What types of dialysis services does your center offer?	Required. Indicate all dialysis service types that are offered by your facility (Select all that apply): <ul style="list-style-type: none"> ○ Peritoneal dialysis ○ Home hemodialysis (includes home, home-assisted, and NxStage^{®1} patients)
b.	What patient population does your center serve?	Required. Indicate what patient population your center serves. <ul style="list-style-type: none"> • Adult only • Pediatric only • Mixed: adult and pediatric
5.	Is your center part of a group or chain of dialysis centers?	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.
a.	If yes, what is the name of the group or chain?	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.
6.	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 NHSN survey data performs patient care in the facility. Select “No” if the person who is primarily responsible for collecting these survey data does not perform patient care in the facility.

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

Survey Question		Instructions for Data Collection
7.	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)?	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.
a.	If yes, in how many long-term care facilities?	Conditionally required. Enter the number of long-term care facilities for which your center provided dialysis services.
A.2.	Surveillance	
8.	Which of the following infections in your peritoneal dialysis patients does your center routinely track? (select all that apply)	Conditionally required. Indicate if your center is actively tracking any of the listed infections: <ul style="list-style-type: none"> • Peritonitis • Exit site infection • Tunnel infection • Other (specify)
9.	Which of the following events in your home hemodialysis patients does your center routinely track? (select all that apply)	Conditionally required. Indicate if your center is actively tracking any of the listed events: <ul style="list-style-type: none"> • Bloodstream infection • Vascular access site infection • Needle/access dislodgement • Air embolism • Catheter breakage or bloodline separation • Other (specify)
10.	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 is able to determine whether a bloodstream infection contributed to the patient’s hospital admission. Select “N/A – not pursued” only if your facility does not routinely try to determine the cause of hospitalizations.
11.	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.

B. Patient and staff census

12.	Was your center operational during the first week of February?	<p>Required. Select “Yes” if your facility was open for hemodialysis treatment during the first week of February (Feb. 1 – Feb. 8) of the survey year. Select “No” if your facility was closed for hemodialysis treatment during the first week of February of the survey year.</p> <ul style="list-style-type: none"> If you select “No,” proceed to answer subsequent questions about your facility’s polices since the first week of February and enter zeros for quantitative questions (if applicable).
13.	How many MAINTENANCE, NON-TRANSIENT dialysis PATIENTS were assigned to your center during the first week of February?	<p>Required. Indicate the total number of all the maintenance, non-transient, dialysis patients assigned to your facility during the first week of February (Feb. 1 – Feb. 8) of the survey year (include home hemodialysis and peritoneal dialysis patients). The sum of 13.a. and 13.b., must be less than or equal to the answer to question 13.</p>
a.	Peritoneal dialysis.	Conditionally required. Indicate how many underwent peritoneal dialysis during the first week of February.
b.	Home hemodialysis	Conditionally required. Indicate how many underwent home hemodialysis during the first week of February. Include home, home-assisted, and NxStage ^{®2} patients.
14.	How many PATIENT CARE staff (full time, part time, or affiliated with) worked in your center during the first week of February? <i>Include only staff who had direct contact with dialysis patients or equipment:</i>	<p>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 (the first seven calendar days of the month) of the survey year. <i>Include only those staff persons whose role involves direct contact with dialysis patients or equipment.</i></p> <ul style="list-style-type: none"> 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.

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a.-h.	Occupational categories	<p>Conditionally required. Of the total number of patient care staff specified in question 14, indicate the number per occupational category. The sum of the occupational categories 14.a. – 20.h. must equal the number of patient care staff indicated in question 14.</p> <ul style="list-style-type: none"> • Nurse/nurse assistant • Dialysis patient-care technician • Dialysis biomedical technician • Social worker • Dietitian • Physicians/physician assistant • Nurse practitioner • Other
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C. Vaccines

15	Of the <u>peritoneal dialysis patient</u> counted in question 13a, how many received:	Conditionally required. Of the total number of maintenance, non-transient <i>peritoneal dialysis</i> patients indicated in question 13a: (Beginning 2021, this question will auto-populate with “0” if 13a equals “0”.)
a.	At least 3 doses of hepatitis B vaccine (ever)?	<p>Indicate how many have ever received at least 3 doses of hepatitis B vaccine.</p> <ul style="list-style-type: none"> • Do not count patients who are in the process of completing the hepatitis B vaccine series. • Include all patients who have received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses to complete the series. • Include patients with documentation of having received 3 or more doses, even if they were not vaccinated at your facility. <p>If no patients received 3 or more doses of the hepatitis B vaccine, enter 0.</p>
b.	The influenza (flu) vaccine for the <u>current/most recent</u> flu season?	<p>Indicate how many received the influenza (flu) vaccine for this flu season (September or later).</p> <ul style="list-style-type: none"> • This question 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 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.



	c. 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. <ul style="list-style-type: none"> If no patients received the pneumococcal vaccine, enter 0.
16.	Of the <u>home hemodialysis patients</u> counted in question 13b, how many received:	Conditionally required. Of the total number of maintenance, non-transient <i>home hemodialysis</i> patients indicated in question 13b: (Beginning 2021, this question will auto-populate with "0" if 13b equals "0".)
	a. At least 3 doses of hepatitis B	Indicate how many ever received at least 3 doses of hepatitis B vaccine. <ul style="list-style-type: none"> Do not count patients who are in the process of completing the series. Include all hemodialysis patients who received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses. Include patients who have documentation of having a complete hepatitis B vaccine series, even if not received at your facility. If no hemodialysis patients received at least 3 doses of the hepatitis B vaccine, enter 0.
	b. The influenza (flu) vaccine for the <u>current/most recent</u> flu season?	Indicate how many received the influenza (flu) vaccine for this flu season (September or later). <ul style="list-style-type: none"> This question 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 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 maintenance, non-transient patients receiving hemodialysis reported receiving the influenza vaccine for the current/most recent flu season, enter 0.
	c. At least one dose of pneumococcal vaccine (ever)?	Indicate in question 13b, indicate how many have ever received at least one dose of the pneumococcal vaccine, even if they were not vaccinated at your facility. <ul style="list-style-type: none"> If no patients received the pneumococcal vaccine, enter 0.
17.	Of the patient care <u>staff members</u> counted in question 14, how many received:	Conditionally required. Of the patient care staff members counted in question 14: (Beginning 2021, this question will auto-populate with "0" if 14 equals "0".)

<p>a.</p>	<p>At least 3 doses of hepatitis B vaccine (ever)?</p>	<p>Indicate how many have ever received at least 3 doses of hepatitis B vaccine.</p> <ul style="list-style-type: none"> Do not count staff members who are in the process of completing the series. Include all staff members who received 3 or more doses, even if the brand of hepatitis B vaccine being used requires four doses. Include patient care staff members who report having received at least 3 doses of hepatitis B vaccine (or for whom there is documentation) even if not received at your facility. If none of the patient care staff members indicated in question 14 have received at least 3 doses of the hepatitis B vaccine ever, enter 0.
<p>b.</p>	<p>The influenza (flu) vaccine for the <u>current/most recent</u> flu season?</p>	<p>Indicate how many received the flu vaccine for the current/most recent flu season (September or later).</p> <ul style="list-style-type: none"> 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 indicated in question 12 have received the influenza vaccine for the current/most recent flu season, enter 0.
<p>18.</p>	<p>Which type of pneumococcal vaccine does your center offer to patients?</p>	<p>Required. Choose only one type of pneumococcal vaccine offered to your facility’s patients:</p> <ul style="list-style-type: none"> Polysaccharide: pneumococcal polysaccharide vaccine, called PPSV23 or Pneumovax®.³ Conjugate: pneumococcal conjugate vaccine, called PCV13 or Prevnar® 13.³ <p>If both types of vaccines are offered, select “Both polysaccharide & conjugate”.</p> <p>If pneumococcal vaccine is not offered, select “Neither offered.”</p>

D. Screening

<p>19.</p> <p>a. Peritoneal patients</p>	<p>Does your center routinely screen patients for hepatitis B surface antigen (HBsAg) upon initiation of care?</p>	<p>Required. Select “Yes” if your center routinely screens patients for hepatitis B upon initiation of care. Select “No” if your center does not screen patients for hepatitis B upon initiation of care.</p>
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b.	Home hemodialysis patients	
20.	<p>Does your center routinely screen patients for hepatitis C antibody (anti-HCV) upon initiation of care?</p> <p>a. Peritoneal patients</p> <p>b. Home hemodialysis patients</p>	<p>Required. Select “Yes” if your center routinely screens patients for hepatitis C upon initiation of care. Select “No” if your center does not screen patients for hepatitis C.</p>
21.	<p>Does your center routinely screen patients for latent tuberculosis infection (LTBI) on admission to your center?</p> <p>a. Peritoneal patients</p> <p>b. Home hemodialysis patients</p>	<p>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.</p>
22.	<p>If your center does routinely screen patients for latent tuberculosis infections (LTBI), what method is used? (select all that apply)</p> <p>a. Peritoneal patients</p> <p>b. Home hemodialysis patients</p>	<p>Required. Select all types of LTBI tests that apply. If a LTBI method which is not used, specify in other.</p> <ul style="list-style-type: none"> <input type="radio"/> Tuberculin Skin Test (TST) <input type="radio"/> Blood test <input type="radio"/> Other (specify)_____

E. Prevention Activities

23.	Is your center actively participating in any of the following prevention initiatives (select all that apply):	<p>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.</p> <ul style="list-style-type: none"> • CDC Making Dialysis Safer for Patients Coalition – facility-level participation • CDC Making Dialysis Safer for Patients Coalition – corporate- or other organization-level participation • The Standardizing Care to improve Outcomes in Pediatric End Stage Renal Disease (SCOPE) Collaborative Peritoneal Dialysis Catheter-related Infection Project • SCOPE Collaborative Hemodialysis Access-related Infection Project • None of the above
24.	In the past year, has your center’s medical director participated in a leadership or educational activity as part of the American Society of Nephrology’s (ASN) Nephrologists Transforming Dialysis Safety (NTDS) Initiative?	<p>Required. The answer to this question must be provided by the center’s medical director.</p> <p>Select “Yes” if during the past year the medical director has participated in a leadership or educational program as part of the ASN’s Nephrologists Transforming Dialysis Safety (NTDS) Initiative (www.asn-online.org/ntds).</p> <p>Select “No” if the medical director has not participated.</p>

F. Peritoneal Dialysis Catheters

25.	For peritoneal dialysis catheters, is antimicrobial ointment routinely applied to the exit site during dressing change?	<p>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. Select “N/A” if your facility does not have a procedure in place to routinely apply antimicrobial ointment to peritoneal dialysis catheter exit sites.</p>
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a.	If yes, what type of ointment is most commonly used? (select one)	<p>Conditionally required. Select one antimicrobial ointment that is most commonly applied to the peritoneal dialysis catheter exit site during dressing changes.</p> <ul style="list-style-type: none"> • Gentamicin • Bacitracin/polymyxin B (e.g., Polysporin®) • Mupirocin • Bacitracin/neomycin/polymyxin B (triple antibiotic) • Povidone-iodine • Bacitracin/gramicidin/polymyxin B (Polysporin® Triple) • Other, specify
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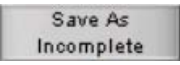
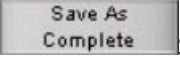
G. Vascular Access

G.1. General Vascular Access Information		
26.	<p>Of the home hemodialysis patients from question 13b, how many received hemodialysis through each of the following access types during the first week of February?</p> <p>a.-e. Hemodialysis access types</p>	<p>Required. Of the total number of maintenance, non-transient home hemodialysis patients indicated in questions 13b, indicate how many patients received hemodialysis through each access type during the first week of February (Feb. 1 – Feb. 8).</p> <ul style="list-style-type: none"> • 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. • Note: Definitions for vascular access types can be found in the Dialysis Event Protocol.
G.2. Arteriovenous (AV) Fistulas or Grafts		
27.	<p>Before prepping the fistula or graft site for rope-ladder cannulation, what is the site most often <u>cleansed</u> with?</p>	<p>Required. Indicate whether the graft/fistula site is most often cleansed with soap and water, or alcohol-based hand rub, prior to prepping the area for puncture.</p> <p>Select “Other” and specify if a different cleanser is used.</p> <p>Select “Nothing” if a cleanser is not used to cleanse the fistula or graft site for cannulation.</p> <ul style="list-style-type: none"> o Soap and water o Alcohol-based hand rub o Other, specify o Nothing
28.	<p>Before rope-ladder cannulation of a fistula or graft, what is the site most often <u>prepped</u> with? (select the one most commonly used)</p>	<p>Required. To prep the graft or fistula for rope-ladder cannulation, select one of the antiseptics/disinfectants that is most often used to prep the area.</p> <p>Select “Nothing” if an antiseptic/disinfectant is not used to prep the graft site.</p>

a.	What form of this skin antiseptic is used to prep fistula/graft sites?	Conditionally required. Indicate the form of the antiseptic/disinfectant used to prep grafts or fistulas for rope-ladder cannulation. Select "N/A" if you answered "Nothing" to question 28.
29.	Does your <u>home</u> hemodialysis facility perform buttonhole cannulation?	Required. Select "Yes" if buttonhole cannulation is performed at the home hemodialysis facility. Select "No" if buttonhole cannulation is not performed at the home hemodialysis facility.
a.	Of AV fistula patients from question 26a, how many had buttonhole cannulation?	Conditionally required. Indicate how many of the AV fistula patients from question 26a had buttonhole cannulation.
b.	When buttonhole cannulation is performed for home hemodialysis patients:	Conditionally required.
i.	Who most often performs it?	Indicate who most often performs buttonhole cannulation for home hemodialysis patients. <ul style="list-style-type: none"> • Patient (self-cannulation) • Caregiver • Other (specify)
ii.	Before cannulation, what is the buttonhole site most often prepped with?	Before cannulation what the site is most often prepped with. Select the one most commonly used. Select "Nothing" if the site is not prepped.
iii.	Is antimicrobial ointment (e.g., mupirocin) routinely used at buttonhole cannulation sites to prevent infection?	Select "Yes" if antimicrobial ointment is applied at the buttonhole cannulation sites to prevent infection. Select "No" if antimicrobial ointment is not used at buttonhole cannulation sites to prevent infection.
G.3. Hemodialysis Catheters		
30.	Are patients who receive hemodialysis through a central venous catheter permitted in your home hemodialysis program?	Required. Select "Yes" if patients with central venous catheters are permitted in your home hemodialysis programs. Select "No" if patients with central venous catheters are not permitted in your home hemodialysis programs.

31.	Before accessing the hemodialysis catheter, what are the catheter hubs most commonly prepped with?	Required. Prior to accessing hemodialysis catheters, select one product that is most commonly used to prep the catheter hubs. Select "Other" and specify what product is most commonly used to prep the catheter hubs if it is not listed. Otherwise, if no product is used to prep the catheter hubs, select "Nothing."
a.	What form of this antiseptic/disinfectant is used to prep the catheter hubs?	Conditionally required. Indicate the form of the antiseptic/disinfectant used to prep catheter hubs prior to accessing hemodialysis catheters. If "Nothing" was selected in question 31 select "N/A".
32.	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)?	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.
33.	When the hemodialysis catheter dressing is changed, what is the exit site (i.e., place where the catheter enters the skin) most commonly <u>prepped</u> with?	Required. When a catheter exit site dressing is changed, select one antiseptic/disinfectant that is most often used to prep the area. Select "Other" if the antiseptic/disinfectant most commonly used to prep the exit site is not listed and specify the antiseptic/disinfectant. Otherwise, if no product is used to prep the exit site, select "Nothing".
a.	What form of this antiseptic/disinfectant is used at the exit site?	Conditionally required. Indicate the form of the antiseptic/disinfectant used to prep catheter exit sites when the dressing is changed. If "Nothing" was selected in question 33, select "N/A".
34.	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.
a.	If yes, what type of ointment is most commonly used?	Conditionally required. Select one antimicrobial ointment that is most commonly applied to the hemodialysis catheter exit site during dressing changes, indicate the type of ointment that is most commonly used.
35.	Are antimicrobial lock solutions used to prevent hemodialysis catheter infections in your center?	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.

a.	If yes, which lock solution is most commonly used?	Conditionally required. Select one type of antimicrobial lock solution that is most commonly used in your facility.
36.	Are needleless closed connector devices (e.g., Tego [®] , Q-Syte [™]) used on hemodialysis catheters in your center?	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.
37.	Are any of the following routinely used for hemodialysis catheters in your center?	Required. Select “Yes” to all 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). Select “No” if your facility does not routinely use the applicable antimicrobial/antiseptic products.
38.	Does your center provide hemodialysis catheter patients with supplies to allow for changing catheter dressings at home?	Required. Select “Yes, routinely for all or most patients with a catheter” 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 for select patients with a catheter” 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.
39. a.	Does your center educate patients with hemodialysis catheters on how to shower with the catheter?	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 shower with the catheters to a select group of catheter patients. Select “No” if your facility has a policy to not provide catheter covers to patients.
b.	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 for all or most patients” if your facility has a policy to provide protective catheter covers to all catheter patients. Select “Yes, only for select patients” 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.

<p>Comments</p>	<p>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.</p>
<p>Save as ...</p> <p> Save as Incomplete</p> <p> Save as Complete</p>	<p>A complete survey is an annual reporting requirement specified in the NHSN Dialysis Event Surveillance Protocol. Users are prevented from creating Monthly Reporting Plans and submitting monthly data for May through December until a survey for that year has been “Saved as Complete.” Surveys can be saved as complete as early as February 8 each year.</p>