The Florida ESRD Network (Network 7) wants to hear from you!

# ***Home Dialysis Patient Education Needs Assessment***

Please complete and return the Needs Assessment to your facility**.**

| **What language are you most comfortable understanding/reading?** | |
|---|---|
| ☐ English ☐ Spanish ☐ Creole ☐ French ☐ Vietnamese ☐ Other. Specify: _____ | |
| **1. Do you know how to file a grievance (complaint)?** | ☐ Yes ☐ No |
| **2. Has your facility explained to you situations that could result in your being involuntarily discharged (forced to leave the facility) from the dialysis unit?** | ☐ Yes ☐ No |
| **3. Are you aware of the Dialysis Facility Compare website? (www.medicare.gov/dialysisfacilitycompare)** | ☐ Yes ☐ No |
| **4. What is your preferred way of receiving health education? (Check up to three.)** | ☐ Video ☐ Internet health newsletters<br>☐ Written ☐ Internet health websites<br>☐ Email information from healthcare providers<br>☐ Face-to-face ☐ Other. Specify: _____ |
| **5. How do you get most of your health education? (Check all that apply.)** | ☐ Network 7 Patient Newsletter ☐ Internet<br>☐ Other newsletters ☐ Support group<br>☐ Other patients ☐ Dialysis staff<br>☐ American Association of Kidney Patients<br>☐ My doctor ☐ Other. Specify:_____ |
| **6. In the last year, I attended my Plan of Care meeting:** | ☐ By phone ☐ In-person ☐ Did not attend |
| **7. Do you think being part of your Plan of Care meeting is important?** | ☐ Yes ☐ No |
| **8. If you attended your Plan of Care meeting, do you think your opinions were heard?** | ☐ Yes ☐ No |
| **9. Please tell us what kind of Dialysis Patient/Family Support Groups you have ever attended or are currently attending. (Check all that apply.)** | ☐ I have never attended a support group<br>☐ Internet support groups/chat rooms<br>☐ Facility support groups during regular business or treatment hours<br>☐ An off-site group meeting after regular business/treatment hours<br>☐ Event oriented support groups |
| **10. How likely would you be to start or promote a support group for your facility if information and materials were provided for you?** | ☐ Extremely Likely ☐ Likely<br>☐ Somewhat Likely ☐ Unlikely |
| **11. If Network 7 were to contact you about participating in a patient-family council, how likely would you be to participate?** | ☐ Extremely Likely ☐ Likely<br>☐ Somewhat Likely ☐ Unlikely |
| **12. Do you know what each of your medications is for?** | ☐ Yes ☐ No |
| **13. How often do you exercise?** | ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely<br>☐ Unable to exercise |

Region:

| | |
|---|---|
| **14. Is it hard for you to control your fluid intake?** | ☐ Yes ☐ No |
| **15. Do you follow your renal diet?** | ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely |
| **16. How important to you is being able to travel?** | ☐ Extremely Important ☐ Very Important<br>☐ Important ☐ Somewhat Important<br>☐ Not Important |
| **17. Has Home Therapy allowed you to maintain a Quality of Life that is similar to before starting dialysis?** | ☐ Yes ☐ No |
| **18. If you were working prior to dialysis, has being on Home Therapy allowed you to keep working?** | ☐ Yes ☐ No ☐ Was not working |
| **19. Which Home Therapy are you currently using?** | ☐ Hemodialysis ☐ Peritoneal Dialysis |
| **20. If you are on Peritoneal Dialysis (PD) do you have an AVF or AVG for back-up hemodialysis?** | ☐ Yes ☐ No |
| **20a. If you do not have a back-up AVF or AVG hemodialysis access placed, why not? (Check all that apply.)** | ☐ I don't think it is important.<br>☐ I am afraid of needles.<br>☐ I am concerned about how it will look.<br>☐ I don't know enough to make a good decision.<br>☐ I am afraid of the side effects of placement.<br>☐ I could not get a surgeon appointment scheduled.<br>☐ I have not been told I need one.<br>☐ I am concerned about paying for it.<br>☐ I had one before and it did not work. |
| **21. Which PD solution do you use most often?** | ☐ 1.50% ☐ 2.50% ☐ 4.25% ☐ Icodextran |
| **22. If you have had an infection in the last six months, what kind of infection(s) did you have? (Check all that apply.)** | ☐ Flu ☐ Pneumonia ☐ Peritonitis ☐ AVF/Graft<br>☐ Other. Specify: _____ ☐ N/A |
| **23. How often do you skip or miss your dialysis treatment?** | ☐ Sometimes ☐ Rarely ☐ Never |
| **24. I am confident in my ability to handle the following problems: (Check all that apply.)** | ☐ Reaching the on-call staff if there is an emergency<br>☐ Recognizing the signs and symptoms of access infection<br>☐ Ordering, storing, and maintaining an inventory of supplies<br>☐ Making sure that my dialysis machine is operating correctly<br>☐ Ensuring that my water supply is safe |
| **25. My facility provided education/information on the following treatment options: (Check all that apply.)** | ☐ Continuous Ambulatory Peritoneal Dialysis<br>☐ Continuous Cycling Peritoneal Dialysis<br>☐ Conventional Home Hemodialysis ☐ No Therapy<br>☐ Nocturnal Hemodialysis ☐ Kidney Transplant<br>☐ Short Daily Hemodialysis ☐ None of these |

## Thank you for Participating!

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