

## Hemovigilance Module Annual Facility Survey

\*Required for saving

\*Facility ID#: \_\_\_\_\_

\*Survey Year: \_\_\_\_\_

*For all questions, use information from last full calendar year.*

### Facility Characteristics

\*1. Ownership: (check one)

- Government     Military     Not for profit, including church     For profit  
 Veteran's Affairs     Managed Care Organization     Physician-owned

\*2. Is your hospital affiliated with a medical school?     Yes     No

If Yes, check type of affiliation:     Major     Graduate     Limited

3. Community setting of facility:     Urban     Suburban     Rural

\*4. How is your hospital accredited? (check one)

- National Integrated Accreditation for Healthcare Organizations (DNV)  
 The Joint Commission     American Osteopathic Association (AOA)  
 Other Accrediting Organization

\*5. Total beds served by Transfusion Services.    \_\_\_\_\_

\*6. Number of surgeries performed per year:    Inpatient:    \_\_\_\_\_    Outpatient:    \_\_\_\_\_

\*7. At what trauma level is your facility certified?     I     II     III     IV     N/A

### Transfusion Services Characteristics

\*8. Primary classification of facility areas served by Transfusion Services: (check all that apply)

- General medical and surgical     Obstetrics and gynecology     Orthopedic     Cancer center  
 Chronic disease     Children's general medical and surgical     Children's orthopedic  
 Children's cancer center     Children's chronic disease     Other (specify) \_\_\_\_\_

\*9. Does your healthcare facility provide all of its own transfusion services, including all laboratory functions?

- Yes     No, we contract with a blood center for some transfusion service functions.  
 No, we contract with another healthcare facility for some transfusion service functions.

\*10. Is your Transfusion Services part of the facility's core laboratory?     Yes     No

\*11. How many dedicated Transfusion Services staff members are there?

Number of technical FTEs (including supervisors)    \_\_\_\_\_

Number of dedicated physician FTEs:    \_\_\_\_\_    Number of MLTs:    \_\_\_\_\_    Number of MTs:    \_\_\_\_\_

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\*12. Does your hospital have a dedicated position or FTE in a quality or patient safety department/function for investigation of transfusion-related adverse reactions?

Yes  No

\*13. Does your hospital have a dedicated position or FTE in a quality or patient safety department/function for investigation of transfusion errors (i.e. incidents)?

Yes  No

\*14. Is your Transfusion Services laboratory accredited?  Yes  No

If Yes, select all that apply:  College of American Pathologists (CAP)  AABB

\*15. Do you have a committee that reviews blood utilization?  Yes  No

\*16. Total number of samples collected: \_\_\_\_\_

\*17. Products and total number of units/aliquots transfused: (check all that apply)

	Units:	Aliquots:
<input type="checkbox"/> Whole blood derived red blood cells	_____	_____
<input type="checkbox"/> Apheresis red blood cells	_____	_____
<input type="checkbox"/> Whole blood derived platelet concentrates	_____	N/A
What is your average pool size? _____		
<input type="checkbox"/> Apheresis platelets	_____	_____
<input type="checkbox"/> Whole blood derived plasma (Incl. FFP, thawed, etc.)	_____	_____
<input type="checkbox"/> Apheresis plasma	_____	_____
<input type="checkbox"/> Cryoprecipitate	_____	N/A
<input type="checkbox"/> Granulocytes	_____	_____
<input type="checkbox"/> Lymphocytes	_____	_____

\*18. Are any of the following administered through Transfusion Services? (check all that apply)

Albumin  Factors (VIIa, VIII, IX, ATIII, etc)  Immunoglobulin (IV)  
 Immunoglobulin (IM or subcutaneous)  RhIg  None

\*19. Does your facility attempt to transfuse only leukocyte-reduced cellular components?

Yes  No

\*20. Are all units stored in the Transfusion Services area?  Yes  No

If No, indicate the location(s) of satellite storage: (check all that apply)

Operating Room  Emergency Room  
 Ambulatory Care  Other: (specify) \_\_\_\_\_

\*21. To what extent does Transfusion Services modify products? (check all that apply)

Aliquot  Deglycerolizing  Irradiation  Leukoreduction  
 Plasma reduction  Pooling  Washing  None of these

\*22. Do you collect blood for transfusion at your facility?  Yes  No

If Yes, check all that apply:  Allogeneic  Autologous  Directed

\*23. Does your facility perform viral testing on blood for transfusion?  Yes  No

24. Units/Aliquots Transfused by Department or Service: (optional)

Department/ Service	Samples Collected		Units/Aliquots Transfused								
			Platelets		Red Blood Cells		Plasma		Cryoprecipitate	Granulocytes	Lymphocytes
			Whole Blood	Apheresis	Whole Blood	Apheresis	Whole Blood	Apheresis			
Emergency Room/ Trauma		Units									
		Aliquots									
Hematology/ Oncology (BMT/Aph)		Units									
		Aliquots									
ICU/NICU		Units									
		Aliquots									
Nephrology/ Dialysis		Units									
		Aliquots									
Obstetrics/ Gynecology		Units									
		Aliquots									
Pediatrics/ Neonatology*		Units									
		Aliquots									
Surgery, Cardiac		Units									
		Aliquots									
Surgery, General		Units									
		Aliquots									
Surgery, Orthopedic		Units									
		Aliquots									
Surgery, Other		Units									
		Aliquots									
Solid Organ Transplant		Units									
		Aliquots									
General Medical, Other		Units									
		Aliquots									

\*Non-Pediatric Facilities Only

**Transfusion Services Computerization**

- \*25. Is Transfusion Services computerized?  Yes  No (If No, skip to next section)  
If Yes, select system(s) used: (check all that apply)  
 Cerner Classic®  Cerner Millennium®  HCLL®  Horizon BB®  Hemocare®  
 Lifeline®  Meditech®  Misys®  Wyndgate® (Safetrace TX)  Softbank®  
 Western Star®  Other (specify) \_\_\_\_\_
- \*26. Is your system ISBT-128 compliant?  Yes  No
- \*27. Does the Transfusion Services system interface with the patient registration system?  Yes  No
- \*28. Are Transfusion Services adverse events entered into a hospital-wide electronic reporting system?  
 Yes  No If Yes, specify system used: \_\_\_\_\_
- \*29. Do you use positive patient ID technology for transfusion services?  
 Yes, hospital wide  Yes, certain areas  Not used  
 If Yes, select purpose(s): (check all that apply)  Specimen collection  Product administration  
 If Yes, select system(s) used: (check all that apply)  
 Mechanical barrier system (e.g., Bloodloc®)  
 Separate transfusion ID wristband system (e.g., Typenex®)  
 Radio frequency identification (RFID)  Bedside ID band barcode scanning  
 Other (specify) \_\_\_\_\_
- \*30. Do you have physician online order entry for test requesting?  Yes  No
- \*31. Do you have physician online order entry for product requesting?  Yes  No

### Transfusion Services Specimen Handling and Testing

- \*32. Are Transfusion Services specimens drawn by a dedicated phlebotomy team?  
 Always  Sometimes, approximately \_\_\_\_\_% of the time  Never
- \*33. What specimen labels are used at your facility? (check all that apply)  
 Handwritten  Addressograph  Computer generated from laboratory test request  
 Computer generated by bedside device  Other (specify) \_\_\_\_\_
- \*34. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?  
 Yes  No
- \*35. What items can be used to verify patient identification during specimen collection and prior to product administration at your facility? (check all that apply)  
 Medical record (or other unique patient ID) number  Date of birth  Gender  
 Patient first name  Patient last name  Transfusion specimen ID system (e.g., Typenex®)  
 Patient verbal confirmation of name or date of birth  Other (specify) \_\_\_\_\_
- \*36. How are routine type and screen done? (check all that apply and estimate frequency of each)  
 Manual technique \_\_\_\_\_%  Automatic technique \_\_\_\_\_%  
 Both automatic and manual technique \_\_\_\_\_% *Total should equal 100%*
- \*37. Is the ABO group of a pre-transfusion specimen routinely confirmed?  Yes  No

If Yes, check one:

- All samples
- If there is no laboratory record of previous determination of patient's ABO group
- If there is no laboratory record of previous determination of patient's ABO group AND the patient is a candidate for electronic crossmatching

If Yes, is the confirmation required on a separately-collected specimen before a unit of Group A, B, or AB red blood cells is issued for transfusion?

- Yes    No

\*38. How many RBC type and screen and crossmatch procedures were performed at your facility by any method?

RBC type and screen: \_\_\_\_\_ RBC crossmatch \_\_\_\_\_

Estimate the % of crossmatch procedures done by each method: (check all that apply)

- Electronically \_\_\_\_\_%    Serologically \_\_\_\_\_%    Don't know   *Total may be >100%*