



Hemovigilance Module Annual Facility Survey

*Required for saving

*Facility ID#: _____

*Survey Year: _____

For all questions, use information from previous 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 TJC

*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) Rhlg 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 Department
- 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. Does your facility perform point-of-issue bacterial testing on platelets prior to transfusion? Yes No

25. 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 Department/ 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			
*26. Is Transfusion Services computerized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No (If No, skip to next section)
If Yes, select system(s) used: (check all that apply)		<input type="checkbox"/> BBCS®	<input type="checkbox"/> BloodTrack Tx® (Haemonetics)
<input type="checkbox"/> Cerner Classic®	<input type="checkbox"/> Cerner Millennium®	<input type="checkbox"/> HCLL®	<input type="checkbox"/> Horizon BB®
<input type="checkbox"/> Lifeline®	<input type="checkbox"/> Meditech®	<input type="checkbox"/> Misys®	<input type="checkbox"/> Safetrace Tx® (Haemonetics)
<input type="checkbox"/> Western Star®	<input type="checkbox"/> Other (specify) _____		
*27. Is your system ISBT-128 compliant?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
*28. Does the Transfusion Services system interface with the patient registration system?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
*29. Are Transfusion Services adverse events entered into a hospital-wide electronic reporting system?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, specify system used: _____	
*30. Do you use positive patient ID technology for transfusion services?			
<input type="checkbox"/> Yes, hospital wide	<input type="checkbox"/> Yes, certain areas	<input type="checkbox"/> Not used	
If Yes, select purpose(s): (check all that apply)		<input type="checkbox"/> Specimen collection	<input type="checkbox"/> Product administration
If Yes, select system(s) used: (check all that apply)			
<input type="checkbox"/> Mechanical barrier system (e.g., Bloodloc®)			
<input type="checkbox"/> Separate transfusion ID wristband system (e.g., Typenex®)			
<input type="checkbox"/> Radio frequency identification (RFID)		<input type="checkbox"/> Bedside ID band barcode scanning	
<input type="checkbox"/> Other (specify) _____			
*31. Do you have physician online order entry for test requesting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
*32. Do you have physician online order entry for product requesting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Transfusion Services Specimen Handling and Testing			
*33. Are Transfusion Services specimens drawn by a dedicated phlebotomy team?			
<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes, approximately _____ % of the time	<input type="checkbox"/> Never	
*34. What specimen labels are used at your facility? (check all that apply)			
<input type="checkbox"/> Handwritten	<input type="checkbox"/> Addressograph	<input type="checkbox"/> Computer generated from laboratory test request	
<input type="checkbox"/> Computer generated by bedside device		<input type="checkbox"/> Other (specify) _____	
*35. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?			
<input type="checkbox"/> Yes	<input type="checkbox"/> No		
*36. What items can be used to verify patient identification during specimen collection and prior to product administration at your facility? (check all that apply)			
<input type="checkbox"/> Medical record (or other unique patient ID) number		<input type="checkbox"/> Date of birth	<input type="checkbox"/> Gender
<input type="checkbox"/> Patient first name	<input type="checkbox"/> Patient last name	<input type="checkbox"/> Transfusion specimen ID system (e.g., Typenex®)	
<input type="checkbox"/> Patient verbal confirmation of name or date of birth		<input type="checkbox"/> Other (specify) _____	
*37. How is routine type and screen done? (check all that apply and estimate frequency of each)			
<input type="checkbox"/> Manual technique	_____ %	<input type="checkbox"/> Automatic technique	_____ %



Both automatic and manual technique		_____ %	<i>Total should equal 100%</i>		
*38. Is the ABO group of a pre-transfusion specimen routinely confirmed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If Yes, check one:					
<input type="checkbox"/> All samples					
<input type="checkbox"/> If there is no laboratory record of previous determination of patient's ABO group					
<input type="checkbox"/> 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?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No			
*39. 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)					
<input type="checkbox"/> Electronically	_____ %	<input type="checkbox"/> Serologically	_____ %	<input type="checkbox"/> Don't know	<i>Total may be >100%</i>