OMB No. 0920-0666
Exp. Date: xx-xx-xxxx
www.cdc.gov/nhsn

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: _____

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

*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:
☐ Whole blood derived red blood cells	_____	_____
☐ Apheresis red blood cells	_____	_____
☐ Whole blood derived platelet concentrates	_____	N/A
What is your average pool size? _____		
☐ Apheresis platelets	_____	_____
☐ Whole blood derived plasma (Incl. FFP, thawed, etc.)	_____	_____
☐ Apheresis plasma	_____	_____
☐ Cryoprecipitate	_____	N/A
☐ Granulocytes	_____	_____
☐ 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 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? ☐ Yes ☐ No (If No, skip to next section)

If Yes, select system(s) used: (check all that apply) ☐ BBCS® ☐ BloodTrack Tx® (Haemonetics)

☐ Cerner Classic® ☐ Cerner Millennium® ☐ HCLL® ☐ Horizon BB® ☐ Hemocare®

☐ Lifeline® ☐ Meditech® ☐ Misys® ☐ Safetrace Tx® (Haemonetics) ☐ Softbank®

☐ Western Star® ☐ Other (specify) _____

*27. Is your system ISBT-128 compliant? ☐ Yes ☐ No

*28. Does the Transfusion Services system interface with the patient registration system? ☐ Yes ☐ No

*29. Are Transfusion Services adverse events entered into a **hospital-wide** electronic reporting system?

☐ Yes ☐ No If Yes, specify system used: _____

*30. 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) _____

*31. Do you have physician online order entry for test requesting? ☐ Yes ☐ No

*32. Do you have physician online order entry for product requesting? ☐ Yes ☐ No

Transfusion Services Specimen Handling and Testing

*33. Are Transfusion Services specimens drawn by a dedicated phlebotomy team?

☐ Always ☐ Sometimes, approximately _____% of the time ☐ Never

*34. 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) _____

*35. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?

☐ Yes ☐ 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)

☐ 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) _____

*37. How is 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%*

*38. 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

*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)

☐ Electronically	_____%	☐ Serologically	_____%	☐ Don't know	*Total may be >100%*