



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

Physician-owned

Yes

No

*2. Is your hospital a teaching hospital for physicians and/or physicians-in-training?

If Yes, check type:

Graduate

Undergraduate

Major

*3. Community setting of facility:

Urban

Suburban

Rural

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

The Joint Commission

American Osteopathic Association (AOA)

National Integrated Accreditation for Healthcare Organizations (DNV)

Other Accrediting Org

*5. Total beds served by the transfusion service. _____

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

I

II

III

IV

N/A

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

Transfusion Service Characteristics

*8. Primary classification of facility areas served by the transfusion service: (check all that apply)

Cancer center

Orthopedic

General medical and surgical

Children's cancer center

Children's

Children's general medical and surgical

Chronic disease

Burn center

Obstetrics and gynecology

Children's chronic

Trauma and ED

Other (specify) _____

disease

*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 service part of the facility's core laboratory?

Yes

No

*11. How many dedicated transfusion service staff members are there? Dedicated physicians: _____

Number of technical staff (including supervisors): _____ MLTs: _____ MTs: _____

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*12. Does your hospital have a dedicated position or FTE in a quality or patient safety function (e.g., TSO) 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 function (e.g., TSO) for investigation of transfusion errors (i.e. incidents)? Yes No

*14. Is your transfusion service laboratory accredited? Yes No

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

*15. Does your facility have a committee that reviews blood utilization? Yes No

*16. Total number of patient samples collected for type and screen or crossmatch: _____

*17. Total number of units/aliquots transfused annually:

	Units:	Aliquots:
Whole blood derived red blood cells	_____	_____
Apheresis red blood cells	_____	_____
Whole blood derived platelet concentrates	_____	_____
What is your average pool size? _____		
Apheresis platelets	_____	_____
Whole blood derived plasma (Incl. FFP, thawed, etc.)	_____	_____
Apheresis plasma	_____	_____
Cryoprecipitate	_____	_____
Granulocytes	_____	_____
Lymphocytes	_____	_____

*18. Are any of the following issued through the transfusion service? (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 or leuko-poor components? Yes No

*20. Are all units stored in the transfusion service? Yes No

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

- Ambulatory Care Cancer Center Cardiac ICU
- Emergency Department Labor and Delivery Medical Flight Facility
- Operating Room Other: (specify) _____

*21. To what extent does the transfusion service 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

Transfusion Service Computerization

*25. Is the transfusion service 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) _____

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

*27. Does the transfusion service system interface with the patient registration system? Yes No

*28. Are the transfusion service adverse events entered into a **hospital-wide** electronic reporting system?

Yes No If Yes, specify system used: _____

*29. Does your facility use positive patient ID technology for the transfusion service?

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. Does your facility have physician online order entry for test requesting? Yes No

*31. Does your facility have physician online order entry for product requesting? Yes No

Transfusion Service Specimen Handling and Testing

*32. Are transfusion service 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 is routine type and screen done? (check all that apply and estimate frequency of each)

Manual technique _____% Automated technique _____%
 Both automated 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%*