



## 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

\*2. Is your hospital a teaching hospital for physicians and/or physicians-in-training?  Yes  No

If Yes, check type:  Major       Graduate       Undergraduate

\*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 Organization

\*5. Total beds served by the transfusion service. \_\_\_\_\_

\*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 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 orthopedic       Children's general medical and surgical  
 Chronic disease       Burn center       Obstetrics/Gynecology  
 Children's chronic disease       Trauma/Emergency       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 the transfusion service part of the facility's core laboratory?  Yes  No

\*11. How many dedicated transfusion service staff members are there? (Count full-time equivalents; include supervisors.)

Physicians: \_\_\_\_\_ Medical Technologists: \_\_\_\_\_ Medical Laboratory Technicians: \_\_\_\_\_

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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 the 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                                      | _____  | _____     |
| What is your average pool size? _____                |        |           |
| 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 cellular 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 the 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%*