Form Approved
OMB No. 0920-0666
Exp. Date: 12/31/22
www.cdc.gov/nhsn

Hemovigilance Module - Annual Facility Survey
Acute Care Facility

*Required for saving

*Facility ID#: _____ *Survey Year: _____

For all questions, use information from previous full calendar year.

Facility Characteristics

NOTE: Questions 1 – 7 are completed automatically (i.e., auto-populated) in the NHSN application with responses from the previous year's survey.

*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
☐ Children's cancer center
☐ Chronic disease
☐ Children's chronic disease
☐ Orthopedic
☐ Children's orthopedic
☐ Burn center
☐ Trauma/Emergency
☐ General medical and surgical
☐ Children's general medical and surgical
☐ Obstetrics/Gynecology
☐ 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: _____

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 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. 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) ☐ RhIg ☐ None

*18. Does your facility attempt to transfuse only leukocyte-reduced or leuko-poor cellular components? ☐ Yes ☐ No

*19. 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) _____

*20. To what extent does the transfusion service modify products? (check all that apply)

☐ Aliquot ☐ Deglycerolizing ☐ Irradiation ☐ Leukoreduction
☐ Plasma reduction ☐ Pooling ☐ Washing ☐ None of these

*21. Do you collect blood for transfusion at your facility? ☐ Yes ☐ No

If Yes, check all that apply: ☐ Allogeneic ☐ Autologous ☐ Directed

*22. Does your facility perform viral testing on blood for transfusion? ☐ Yes ☐ No

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

Transfusion Service Computerization

*24. 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®

NHSN National Healthcare Safety Network

☐ Lifeline® ☐ Meditech® ☐ Misys® ☐ Safetrace Tx® (Haemonetics) ☐ Softbank®
☐ Western Star® ☐ Other (specify) _____

*25. Is the system ISBT-128 compliant? ☐ Yes ☐ No

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

*27. Are the transfusion service adverse events entered into a **hospital-wide** electronic reporting system?
☐ Yes ☐ No If Yes, specify system used: _____

*28. 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) _____

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

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

Transfusion Service Specimen Handling and Testing

*31. Are transfusion service specimens drawn by a dedicated phlebotomy team?
☐ Always ☐ Sometimes, approximately _____% of the time ☐ Never

*32. 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) _____

*33. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?
☐ Yes ☐ No

*34. 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
☐ Sex at Birth ☐ Gender Identity ☐ Other (specify) _____

*35. 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%*

*36. 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

*37. 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%*