

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
 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: _____

*12. Does your hospital have a dedicated position or FTE in a quality or patient safety Yes No

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function (e.g., TSO) for investigation of transfusion-related adverse reactions?

*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) Rhlg 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®
 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
 Gender identity
 Sex at birth
 Patient first name
 Patient last name
 Transfusion specimen ID system (e.g., Typenex®)
 Patient verbal confirmation of name or date of birth
 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%*