**Hemovigilance Module - Annual Facility Survey**

**Acute Care Facility**

**\*Required for saving**

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| --- | --- |
| \*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 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® |
| [ ]  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 |  |
| [ ]  Sex |  |  |  |
| [ ]  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%* |