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# 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 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

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*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®)

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☐ 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%*