Table 1. Hemovigilance Module Annual Facility Survey – Acute Care Facility (CDC 57.300)

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

Data Field	Instructions for Form Completion
Facility ID#	The NHSN-assigned Facility ID number will be auto entered by the system.
Survey Year	Required. Enter the most recent full calendar year. For example, if you are completing this survey in February 2008, the survey year will be 2007.
Facility Characteristics *(Note: Section automatically populated from previously saved survey)*	
1. Ownership	**Required.** Check the ownership type that most closely describes your facility.
2. Is your hospital a teaching hospital for physicians and/or physicians-in-training?	**Required.** Check **Yes** if your hospital is a teaching hospital for physicians and/or physicians-in-training.
Type of affiliation	**Conditional.** If Yes, select type of affiliation: **Major** affiliation: Facility has a program for medical students and post-graduate medical training. **Graduate** affiliation: Facility has a program for post-graduate medical training (i.e., residency and/or fellowships). **Undergraduate** affiliation: Facility has a program for medical students only.
3. Community setting of facility:	**Required.** Check the setting that most closely describes the location of your facility. **Urban**: Areas classified as a Metropolitan Statistical Area by the U.S. Census Bureau; each area must have at least one urbanized area of 50,000 or more inhabitants. **Suburban:** Areas classified as a Micropolitan Statistical Area by the U.S. Census Bureau; each Micropolitan statistical area must have at least one urban cluster of at least 10,000 but less than 50,000 inhabitants. **Rural:** Areas classified as Balance of County by the U.S. Census Bureau; there are no urban areas of at least 10,000 inhabitants.
4. How is your hospital accredited?	**Required.** Select the organization that accredits your facility.
5. Total beds served by the transfusion service.	**Required.** Total beds in the facility served by the transfusion service. **Count inpatient and outpatient areas.**

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6. Number of surgeries performed per year:	**Required.** Enter the total number of inpatient and outpatient surgeries performed at your facility in the past full calendar year.
7. At what trauma level is your facility certified?	**Required.** Indicate the trauma level (1, 2, 3, 4, NA) of your facility.
Transfusion Service Characteristics	
8. Primary classification of facility areas served by the transfusion service:	**Required.** Check all facility areas served by the transfusion service.
9. Does your healthcare facility provide all of its own transfusion services, including all laboratory functions?	**Required.** If transfusion services and laboratory support are provided 100% by the facility, check **Yes**. If **No**, select the description that most closely represents your facility's transfusion service structure.
10. Is the transfusion service part of the facility's core laboratory?	**Required.** Check **Yes** if your transfusion service functions as a part of the core laboratory rather than as an independent department.
11. How many dedicated transfusion service staff members are there? (Count full-time equivalents; including supervisors.)	**Required.** Consider 2 part-time workers as a single full time equivalent (FTE). Include supervisors. Technical FTEs include Medical Laboratory Technicians and Medical Technologists.
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?	**Required.** Indicate whether your facility employs a person or FTE responsible for overseeing the investigation of all transfusion-related adverse reactions. The medical director, managers, supervisors, or others that may also serve this purpose within the transfusion service executive management should not be included.
13. Does your hospital have a dedicated position or FTE in a quality or patient safety function (e.g., TSO) for investigation of errors (i.e. incidents)?	**Required.** Indicate whether your facility employs a person or FTE responsible for overseeing the investigation of all transfusion errors. The medical director, managers, supervisors, or others within the transfusion service executive management should not be included.
14. Is the transfusion service lab accredited?	**Required.** If **Yes**, check the accrediting organization(s).
15. Does your facility have a committee that reviews blood utilization?	**Required.** Check **Yes** if a formal committee has been established that meets regularly to review blood utilization.
16. Total number of patient samples collected for type and screen or crossmatch:	**Required.** Enter the total number of patient samples collected for type and screen or crossmatch **in the past full calendar year.**
17. Are any of the following issued through the transfusion service?	**Required.** Check all products that are maintained and ordered through the transfusion service, or check **None**.
18. Does your facility attempt to transfuse only leukocyte-	**Required.** Check **Yes** if it is facility policy to transfuse only leukocyte-reduced or leuko-poor cellular components, even

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reduced or leuko-poor cellular components?	if some non leukocyte-reduced or non leuko-poor products are used on occasion.
19. Are all units stored in the transfusion service?	**Required.** If some units are routinely stored in other parts of your facility, check **No**.
Locations of satellite storage	**Conditional.** If **No**, check facility location(s) where units are also routinely stored.
20. To what extent does the transfusion service modify products?	**Required.** Check only the processes that are performed within the transfusion service.
21. Do you collect blood for transfusion at your facility?	**Required.** Check **Yes** if your facility performs blood collection in-house.
Type of blood collection	Conditionally required. If **Yes**, check all uses that apply.
22. Does your facility perform viral testing on blood for transfusion?	**Required.** If viral testing is performed, but not in-house, check **No**.
23. Does your facility perform point-of-issue bacterial testing on platelets prior to transfusion?	**Required.** Check **Yes** if your facility performs point-of-issue bacterial testing on platelets.
Transfusion Service Computerization	
24. Is the transfusion service computerized?	Required. If your department uses an electronic system for any part of the blood product issuing process, check **Yes**. If **No**, skip to the **Handling and Testing** section.
System(s) used	Conditionally required. If **Yes**, Check all systems used in the transfusion service department.
25. Is your system ISBT-128 compliant?	Conditionally required. Check **Yes** if your department uses the ISBT-128 code system for unit labeling.
26. Does the transfusion service system interface with the patient registration system?	Conditionally required. Check **Yes** if the transfusion service computer system directly accesses the patient registration system (i.e., electronic interface and exchange of information).
27. Are the transfusion service adverse events entered into a **hospital-wide** electronic reporting system?	Conditionally required. Check **Yes** if adverse events, including adverse reactions and/or medical incidents, reported to or occurring within your department are entered into a system that is used across your facility (as opposed to a system that is maintained entirely within your department).
28. Does your facility use positive patient ID technology for the transfusion service?	Conditionally required. Check **Yes** if your facility uses positive patient ID technology for the transfusion service, and indicate the extent to which it is used.
For what purpose(s)?	Conditionally required. If **Yes**, check all uses that apply.
System(s) used	Conditionally required. If **Yes**, check all systems that apply.
29. Does your facility have physician online order entry for test requesting?	Conditionally required. Check **Yes** if a physician can order laboratory testing directly through a computer system.

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30. Does your facility have physician online order entry for product requesting?	Conditionally required. Check **Yes** if a physician can order blood products directly through a computer system.
Transfusion Service Specimens Handling and Testing	
31. Are transfusion service specimens drawn by a dedicated phlebotomy team?	Required. Indicate the frequency with which samples for transfusion service are drawn by dedicated phlebotomy staff as opposed to patient care area staff or other staff.
32. What specimen labels are used at your facility?	Required. Indicate the type(s) of labels used for patient identification on the sample tube.
33. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?	Required. Check **Yes** if phlebotomy staff members are allowed to manually correct name, medical record number, etc., on the specimen label at the time of sample collection.
34. What items can be used to verify patient identification during specimen collection and prior to product administration at your facility?	Required. Check all pieces of information that can be used to verify patient identification **as specified in your hospital policy**.
35. How is routine type and screen done?	Required. Check all that apply and estimate the frequency for each method checked. The total should equal 100%.
36. Is the ABO group of a pre-transfusion specimen routinely confirmed?	Required. Indicate whether the ABO group of a pre-transfusion specimen is routinely confirmed.
Under what circumstances?	Conditionally required. If **Yes**, indicate the circumstance that requires routine ABO group confirmation.
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?	Conditionally required. Check **Yes** if a separately-collected specimen is required for confirmation prior to transfusion of Group A, B, or AB red blood cells.
37. How many RBC type and screen and crossmatch procedures were performed at your facility by any method?	Required. Enter the number of RBC type and screen and RBC crossmatch procedures that were performed by any method **in the past full calendar year.**
Crossmatch method frequency.	Conditionally required. If crossmatch procedures were done, estimate the frequency of each method by which crossmatch was performed. Total may be >100%.