

Hemovigilance Module - Annual Facility Survey Non-Acute Care Facility

***Required for saving**

*Facility ID#: _____

*Survey Year: _____

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

Facility Characteristics

***1. Ownership: (check one)**

- ☐ Government ☐ Military ☐ Not for profit, including church
☐ For profit ☐ Veteran's Affairs ☐ Physician-owned

***2. Community setting of facility:** ☐ Urban ☐ Suburban ☐ Rural

***3. Total number of operating rooms at time of survey completion:** _____

***4. Total number of procedure rooms at time of survey completion:** _____

***5. Total number of patient admissions in this survey year:** _____

***6. Check all the specialty(ies) currently performed in your facility:**

- ☐ Bariatrics ☐ General surgery ☐ Gastroenterology
☐ Gynecology ☐ Neurology ☐ Orthopedic
☐ Plastic surgery ☐ Spine ☐ Urology
☐ Other (specify) _____

Transfusion Service Characteristics

***7. Does your 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.
☐ No, we contract with another blood center for all transfusion service functions.
☐ No, we contract with another healthcare facility for all transfusion service functions.

***8. How many dedicated transfusion service staff members are there? (Count full-time equivalents; include supervisors.)**

Physicians: _____ Medical Technologists: _____ Medical Laboratory Technicians: _____

***9. Does your facility 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

***10. Does your facility 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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Transfusion Service Characteristics (continued)

- *11. Does your facility have a committee that reviews blood utilization? ☐ Yes ☐ No
- *12. Total number of patient samples collected for type and screen or crossmatch: _____
- *13. Does your facility perform point-of-issue bacterial testing on platelets prior to transfusion? ☐ Yes ☐ No

Transfusion Service Computerization

- *14. Is the transfusion service computerized? ☐ Yes ☐ No (If No, skip to question 17)
- 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) _____
- *15. Is the system ISBT-128 compliant? ☐ Yes ☐ No
- *16. Does the transfusion service system interface with the patient registration system? ☐ Yes ☐ No
- *17. Does your facility use positive patient ID technology for transfusion?
- ☐ Yes, facility 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) _____

Transfusion Service Specimen Handling and Testing

- *18. Are transfusion service specimens drawn by a dedicated phlebotomy team?
- ☐ Always ☐ Sometimes, approximately _____% of the time ☐ Never
- *19. 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) _____
- *20. Are phlebotomy staff members allowed to correct patient identification errors on pre-transfusion specimen labels?
- ☐ Yes ☐ No
- *21. 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) _____