



Table 1. Hemovigilance Module Annual Facility Survey (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	
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	Conditionally required. 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.
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.



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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. Total number of units/aliquots transfused annually:	Required. Provide the total number of units and/or aliquots transfused in the past calendar year of each product type. The total number of units and aliquots must be ≥ 0 . Do not include the units from which the aliquots were made in your unit count. <i>Note: If WBD platelet concentrates are transfused, enter the number of pooled units transfused regardless of the number of individual donor concentrates added to the pooled unit. For example, a 6 pool unit would equal 1 unit transfused. Enter the average pool size of</i>



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	<i>transfused units. If cryoprecipitates are transfused, enter the number of individual concentrates pooled into each therapeutic dose. For example, if 6 individual units were pooled to create one cryoprecipitate dose, enter 6 units on the survey.</i>
18. 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 .
19. Does your facility attempt to transfuse only leukocyte-reduced or leuko-poor cellular components?	Required. Check Yes if it is <u>facility policy</u> to transfuse only leukocyte-reduced or leuko-poor cellular components, even if some non leukocyte-reduced or non leuko-poor products are used on occasion.
20. 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	Conditionally required. If No , check facility location(s) where units are also routinely stored.
21. To what extent does the transfusion service modify products?	Required. Check only the processes that are performed within the transfusion service.
22. 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.
23. Does your facility perform viral testing on blood for transfusion?	Required. If viral testing is performed, but not in-house, check No .
24. 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	
25. 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.
26. Is your system ISBT-128 compliant?	Conditionally required. Check Yes if your department uses the ISBT-128 code system for unit labeling.
27. 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).
28. 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).



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29. 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.
30. 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.
31. 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	
32. 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.
33. What specimen labels are used at your facility?	Required. Indicate the type(s) of labels used for patient identification on the sample tube.
34. 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.
35. 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.
36. 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%.
37. 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.
38. 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



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	done, estimate the frequency of each method by which crossmatch was performed. Total may be >100%.