**Table 1. Hemovigilance Module Annual Acute Care 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. |
| 1. 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. |
| 1. 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. |
| 1. How is your hospital accredited? | **Required.** Select the organization that accredits your facility. |
| 1. Total beds served by the transfusion service. | **Required.** Total beds in the facility served by the transfusion service. **Count inpatient and outpatient areas.** |
| 1. 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. |
| 1. At what trauma level is your facility certified? | **Required.** Indicate the trauma level (1, 2, 3, 4, NA) of your facility. |
| **Transfusion Service Characteristics** | |
| 1. Primary classification of facility areas served by the transfusion service: | **Required.** Check all facility areas served by the transfusion service. |
| 1. 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. |
| 1. 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. |
| 1. 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. |
| 1. 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. |
| 1. 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. |
| 1. Is the transfusion service lab accredited? | **Required.** If **Yes**, check the accrediting organization(s). |
| 1. 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. |
| 1. 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.** |
| 1. 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. *Note: Enter the* ***average pool size*** *of transfused units. If WBD platelet concentrates or 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.* |
| 1. 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**. |
| 1. Does your facility attempt to transfuse only leukocyte-reduced or leuko-poor cellular components? | **Required.** Check **Yes** if it is facility policy 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. |
| 1. 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. |
| 1. To what extent does the transfusion service modify products? | **Required.** Check only the processes that are performed within the transfusion service. |
| 1. 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. |
| 1. Does your facility perform viral testing on blood for transfusion? | **Required.** If viral testing is performed, but not in-house, check **No**. |
| 1. 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** | |
| 1. 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. |
| 1. Is your system ISBT-128 compliant? | Conditionally required. Check **Yes** if your department uses the ISBT-128 code system for unit labeling. |
| 1. 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). |
| 1. 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). |
| 1. 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. |
| 1. 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. |
| 1. 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** | |
| 1. 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. |
| 1. What specimen labels are used at your facility? | Required. Indicate the type(s) of labels used for patient identification on the sample tube. |
| 1. 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. |
| 1. 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**. |
| 1. 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%. |
| 1. 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. |
| 1. 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%. |