Table 1. Hemovigilance Module Annual Facility Survey – Non-Acute Care Facility (CDC 57.306)

*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. 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.
3. Total number of operating rooms at time of survey completion:	**Required.** Record the total number of operating rooms in this facility at the time of survey completion. The NHSN definition of an operating room is a patient care area that meets the Facilities Guidelines Institute's (FGI) or American Institute of Architects' (AIA) criteria for an operating room when it was constructed, or renovated. If none, enter "0" (do not leave blank). *Facilities Guidelines Institute. Guidelines for design and construction of health care facilities. American Society for Healthcare Engineering; Chicago IL; 2010.*
4. Total number of procedure rooms at time of survey completion:	**Required.** Record the total number of additional rooms where procedures are performed at this facility. This total should not include the number of operating rooms, as defined in the previous question. If none, enter "0" (do not leave blank).
5. Total number of patient admissions in this survey year:	**Required.** Record the total number of patient admissions to this facility for the survey year.

Data Field	Instructions for Form Completion
6. Check all the specialty(ies) currently performed in your facility:	**Required.** Select all specialties performed in this facility. If "Single specialty" was selected for the preceding question, only one specialty should be selected. If "Multispecialty" was selected for the preceding question, select all specialties that are performed. If your facility performs a specialty that is not listed, please select "Other" as appropriate and specify the type of specialty: • Bariatrics • General surgery • Gastroenterology • Gynecology • Neurology • Orthopedic • Plastic surgery • Spine • Urology
Transfusion Service Characteristics	
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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.**
13. 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.

Data Field	Instructions for Form Completion
Transfusion Service Computerization	
14. 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 **question 17**.
System(s) used	Conditionally required. If **Yes**, Check all systems used in the transfusion service department.
15. Is your system ISBT-128 compliant?	Conditionally required. Check **Yes** if your department uses the ISBT-128 code system for unit labeling.
16. 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).
17. Does your facility use positive patient ID technology for the transfusion service?	**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.
Transfusion Service Specimens Handling and Testing	
18. 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.
19. What specimen labels are used at your facility?	**Required.** Indicate the type(s) of labels used for patient identification on the sample tube.
20. 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.
21. 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**.