Hospital Name:	_____		
Address:	_____		
Respondent's Name:	_____	Date Completed:	_____
Respondent's Phone:	_____	Respondent's Email:	_____

Are you currently accredited by **ANY** of the entities listed below?
If YES – Please provide a copy of the current certification with this form.

AABB
CAP
HFAP
Other (please list) _____ ☐ **Yes** ☐ **No**

1. Does your facility continuously monitor and record the temperature of all blood product storage devices including platelet incubators, or do you record the temperature at least every four (4) hours if continuous monitoring is not available? (if not using an incubator, rotator & room temp must be monitored). ☐ **Yes** ☐ **No**
2. Does your facility have qualified storage and transport devices that have the capacity and design to ensure the proper temperature of blood products is maintained? ☐ **Yes** ☐ **No**
3. Are blood products stored in other areas of your facility? (i.e., ER, surgical or obstetric suites) ☐ **Yes** ☐ **No**
4. Do all your facility's blood product storage devices have alarms to warn of temperature deviations? ☐ **Yes** ☐ **No**
   a. If YES to #4 – are the alarms set to activate under conditions that will allow immediate action to be taken before the blood products reach unacceptable conditions? ☐ **Yes** ☐ **No**
   b. If YES to #4 – does activation of the alarm initiate a process for immediate investigation and appropriate corrective action? ☐ **Yes** ☐ **No**
   c. If YES to #4 – is the alarm audible and monitored 24 hours a day? ☐ **Yes** ☐ **No**
5. Does your facility have written procedures to ensure blood products are not removed from validated storage and/or transport devices for more than 30 minutes? ☐ **Yes** ☐ **No**
6. Does your facility have written procedures for the storage and handling of blood products to prevent damage and limit deterioration in the case of storage unit malfunction or power failure? ☐ **Yes** ☐ **No**
7. Is each blood product storage unit on emergency power? ☐ **Yes** ☐ **No**
8. Does your facility have a quality control program to ensure blood product storage and transport devices, including platelet incubators & rotators, function as expected? (i.e. alarm activation checks) ☐ **Yes** ☐ **No**
9. Does your facility have a written procedure for handling blood products that are outdated, leaking, broken, discolored, or have an unusual appearance; and are visual inspections performed at pre-determined points in your processes? ☐ **Yes** ☐ **No**
10. Is access by unauthorized personnel limited in your blood bank / laboratory or other blood product storage areas? ☐ **Yes** ☐ **No**
11. Is the documentation referenced in this assessment available for review by CBC/CTS if needed? ☐ **Yes** ☐ **No**

***Please return completed forms within the 1st Quarter via eFax to:**

Kathy Paulick, MT (ASCP)
Quality Systems Coordinator
Quality/Regulatory Affairs
CBC/CTS
349 South Main St.
Dayton, Ohio 45402-2715

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Email: kpaulick@cbccts.org