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

Please indicate "YES" or "NO" for the following questions:

Are you currently accredited by **ANY** of the following: AABB CAP HFAP Other (please list) _____ If **YES** – Please provide current certification with this form.		**Yes**	**No**
1.	Does your facility continuously monitor and record the temperature of all blood product storage devices To include platelet incubators or record the temperature at least every four (4) hours if continuous Monitoring is not available? (if not using incubator must monitor rotator & room temp)	**Yes**	**No**
2.	Does your facility have validated storage and transport devices that have the capacity and design to ensure that 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 proper 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.	Are each of the blood product storage units on emergency power?	**Yes**	**No**
8.	Does your facility have a quality control program to ensure blood product storage and transport devices to include platelet incubators & rotators functions 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	Does your facility have a written procedure for handling blood products that are outdated, leaking, broken, discolored, or have an unusual appearance; and are visual inspections performed during pre-determined points in your processes?	**Yes**	**No**
10.	Is access by unauthorized personnel limited to 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

Efax: (937) 913-5611
Email: kpaulick@cbccts.org

Quality Systems Coordinator Review:		**Date:**	
Additional Information Requested:		**Date:**	
Information Received/Date:			
Comments:			
Assessment Completed/Date & Initial:			

Applies To:	**Quality Systems Coordinator, Transfusion Safety Director, Hospitals**
Review/Approval Requirements:	**Quality Systems Coordinator, Quality/Regulatory Affairs Director, Transfusion Safety Director, CEO**

REVISION TRACKING

Explanation of Changes *(include what changed including reason, when applicable)*	**Change Initiated By**	**Implementation Date**
Formerly QA Form #190 : Blood Product Storage Assessment; Updated form to comply with 2009 QA Internal Audit & Recommendations from COO & Transfusion Safety Director.	RE	12-4-09
FILE ONLY - Changed Quality/Regulatory Affairs Specialist to Quality Systems Coordinator throughout; also updated information from Rachel Emerson to Kathy Paulick.	LC	1-18-10