**Hemovigilance Module**

**Monthly Incident Summary**

\*Required for saving

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| \*Facility ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***All reporting is facility-wide. Include numbers of individual incident reports in the totals.*** |
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| **\*Process Code** | **\*Incident Code** | **\*Total****Incidents** | **\*Total Adverse Reactions** |
| **PC: Product Check-In**(Transfusion Service)Events that occur during the shipment and receipt of products into the transfusion service from the supplier, another hospital site, satellite storage, or clinical area. | PC 00 Detail not specified |  |  |
| PC 01 Data entry incomplete/incorrect/not performed |  |  |
| PC 02 Shipment incomplete/incorrect |  |  |
| PC 03 Products and paperwork do not match |  |  |
| PC 04 Shipped/transported under inappropriate conditions |  |  |
| PC 05 Inappropriate return to inventory |  |  |
| PC 06 Product confirmation incorrect/not performed |  |  |
| PC 07 Administrative check not incorrect/not performed (record review/audit) |  |  |
| PC 08 Product label incorrect/missing |  |  |
| **US: Product Storage**(Transfusion Service)Events that occur during product storage by the transfusion service. | US 00 Detail not specified |  |  |
| US 01 Incorrect storage conditions |  |  |
| US 03 Inappropriate monitoring of storage device |  |  |
| US 04 Unit stored on incorrect shelf (e.g., ABO/autologous/directed) |  |  |
| US 05 Incorrect storage location |  |  |
| **IM: Inventory Management** (Transfusion Service)Events that involve quality management of the blood product inventory. | IM 00 Detail not specified |  |  |
| IM 01 Inventory audit incorrect/not performed |  |  |
| IM 02 Product status incorrectly/not updated online (e.g., available/discarded) |  |  |
| IM 03 Supplier recall/traceback not appropriately addressed/not performed |  |  |
| IM 04 Product order incorrectly/not submitted to supplier |  |  |
| IM 05 Outdated product in available inventory |  |  |
| IM 06 Recalled/quarantined product in available inventory |  |  |
| **PR: Product/Test Request**(Clinical Service)Events that occur when the clinical service orders patient tests or blood products for transfusion. | PR 00 Detail not specified |  |  |
| PR 01 Order for wrong patient |  |  |
| PR 02 Order incompletely/incorrectly ordered (online order entry) |  |  |
| PR 03 Special processing needs not indicated (e.g., CMV negative, autologous) |  |  |
| PR 04 Order not done |  |  |
| PR 05 Inappropriate/unnecessary (intended) test ordered |  |  |
| PR 06 Inappropriate/unnecessary (intended) blood product ordered |  |  |
| PR 07 Incorrect (unintended) test ordered |  |  |
| PR 08 Incorrect (unintended) blood product ordered |  |  |
| **OE: Product/Test Order Entry**(Transfusion Service)Events that occur when the transfusion service receives a patient order. This process may be excluded if clinical service uses online ordering. | OE 00 Detail not specified |  |  |
| OE 01 Order entered for wrong patient |  |  |
| OE 02 Order incompletely/incorrectly entered online |  |  |
| OE 03 Special processing needs not entered (e.g., CMV-, autologous) |  |  |
| OE 04 Order entry not done |  |  |
| OE 05 Inappropriate/unnecessary (intended) test order entered |  |  |
| OE 06 Inappropriate/unnecessary (intended) blood product order entered |  |  |
| OE 07 Incorrect (unintended) test ordered |  |  |
| OE 08 Incorrect (unintended) blood product ordered |  |  |
| Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS H21-8, Atlanta, GA 30333, ATTN: PRA (0920-0666). |
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| **\*Process Code** | **\*Incident Code** | **\*Total****Incidents** | **\*Total Adverse Reactions** |
| **SC: Sample Collection**(Service collecting the samples)Events that occur during patient sample collection. | SC 00 Detail not specified |  |  |
| SC 01 Sample labeled with incorrect patient ID (intended patient drawn) |  |  |
| SC 02 Sample not labeled |  |  |
| SC 03 Wrong patient collected (sample labeled for intended patient) |  |  |
| SC 04 Sample collected in wrong tube type |  |  |
| SC 05 Sample quantity not sufficient (QNS) |  |  |
| SC 06 Sample hemolyzed |  |  |
| SC 07 Sample label incomplete/illegible for patient identifiers  |  |  |
| SC 08 Sample collected in error (e.g., unnecessary/duplicate) |  |  |
| SC 09 Patient sample not collected (in error) |  |  |
| SC 10 Patient wristband incorrect/not available  |  |  |
| SC 11 Sample contaminated |  |  |
| **SH: Sample Handling**(Service collecting the samples)Events that occur when a patient sample is sent for testing. | SH 00 Detail not specified |  |  |
| SH 01 Sample sent without requisition |  |  |
| SH 02 Requisition and sample label don’t match |  |  |
| SH 03 Patient ID incomplete/illegible on requisition |  |  |
| SH 04 No Patient ID on requisition |  |  |
| SH 05 No phlebotomist/witness identification |  |  |
| SH 06 Sample sent with incorrect requisition type |  |  |
| SH 07 Patient information (other than ID) missing/incorrect on requisition |  |  |
| SH 08 Requisition sent without sample |  |  |
| SH 09 Data entry incorrect/incomplete/not performed |  |  |
| SH 10 Sample transport issue (e.g., sample broken/inappropriate conditions) |  |  |
| SH 11 Duplicate sample sent in error |  |  |
| **SR: Sample Receipt**(Transfusion Service)Events that occur when a sample is received by the transfusion service. | SR 00 Detail not specified |  |  |
| SR 01 Sample accepted in error |  |  |
| SR 02 Historical review incorrect/not performed |  |  |
| SR 03 Demographic review/ data entry incorrect/not performed |  |  |
| SR 04 Sample incorrectly accessioned  |  |  |
| **ST: Sample Testing**(Transfusion Service)Events that occur during **patient sample** testing by the transfusion service. | ST 00 Detail not specified |  |  |
| ST 01 Data entry incomplete/incorrect/not performed |  |  |
| ST 02 Appropriate sample checks incomplete/incorrect/not performed |  |  |
| ST 03 Computer warning overridden in error or outside SOP |  |  |
| ST 05 Sample test tube incorrectly accessioned |  |  |
| ST 07 Sample test tubes mixed up |  |  |
| ST 09 Sample test tube mislabeled (wrong patient identifiers) |  |  |
| ST 10 Equipment problem/failure/not properly QC’d |  |  |
| ST 12 Sample testing not performed |  |  |
| ST 13 Incorrect sample testing method chosen |  |  |
| ST 14 Sample testing performed incorrectly |  |  |
| ST 15 Sample test result misinterpreted |  |  |
| ST 16 Reagents used were incorrect/inappropriate/expired/not properly QC’d |  |  |
| ST 17 ABO/Rh error caught on final check |  |  |
| ST 18 Current/historical ABO/Rh mismatch  |  |  |
| ST 19 Additional testing not performed |  |  |
| ST 20 Confirmatory check incorrect/not performed (at time work performed) |  |  |
| ST 21 Administrative check incorrect/not performed (record review/audit) |  |  |
| ST 22 Sample storage incorrect/inappropriate |  |  |
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| **\*Process Code** | **\*Incident Code** | **\*Total****Incidents** | **\*Total Adverse Reactions** |
| **UM: Product Manipulation/****Processing/Testing**(Transfusion Service)Events that occur while testing, manipulating (e.g., pooling, washing, aliquoting, irradiating), processing, or labeling blood products. | UM 00 Detail not specified |  |  |
| UM 01 Data entry incomplete/incorrect/not performed |  |  |
| UM 02 Record review incomplete/incorrect/not performed |  |  |
| UM 03 Incorrect product (type) selected  |  |  |
| UM 04 Incorrect product (patient) selected |  |  |
| UM 05 Product labeled incorrectly (new/updated) |  |  |
| UM 06 Computer warning overridden in error or outside SOP |  |  |
| UM 07 Special processing needs not checked |  |  |
| UM 08 Special processing needs misunderstood or misinterpreted |  |  |
| UM 09 Special processing needs performed incorrectly  |  |  |
| UM 10 Special processing needs not performed |  |  |
| UM 11 Equipment problem/failure/not properly QC’d |  |  |
| UM 12 Reagents used were incorrect/inappropriate/expired/not properly QC’d |  |  |
| UM 13 Confirmatory check incorrect/not performed (at time work performed) |  |  |
| UM 14 Administrative check incorrect/not performed (record review/audit) |  |  |
| **No Blood** | NB 01 Inventory less than usual par level due to supplier unable to meet usual steady demand |  |  |
| NB 02 Demand for blood product exceeding usual par inventory level |  |  |
| NB 03 Incompatible/inappropriate units issued due to inventory constraints when demand for blood product exceeds usual par inventory levels. |  |  |
| NB 04 Suboptimal dose (less than optimal quantity) transfusion or no transfusion due to inventory constraints when demand for blood product exceeds usual par inventory levels. |  |  |
| **RP: Request for Pick-Up**(Clinical Service)Events that occur when the clinical service requests pick-up of a blood product from the transfusion service. | RP 00 Detail not specified |  |  |
| RP 01 Request for pick-up on wrong patient |  |  |
| RP 02 Incorrect product requested for pick-up |  |  |
| RP 03 Product requested prior to obtaining consent |  |  |
| RP 04 Product requested for pick-up, but patient not available |  |  |
| RP 05 Product requested for pick-up, but IV not ready |  |  |
| RP 06 Request for pick-up incomplete (e.g., patient ID/product type missing) |  |  |
| RP 07 Pick-up slip did not match patient information on product |  |  |
| **UI: Product Issue**(Transfusion Service)Events that occur when the transfusion service issues blood product to the clinical service.  | UI 00 Detail not specified |  |  |
| UI 01 Data entry incomplete/incorrect/not performed |  |  |
| UI 02 Record review incomplete/incorrect/not performed |  |  |
| UI 03 Product issued for wrong patient  |  |  |
| UI 04 Product issued out of order |  |  |
| UI 05 Product issue delayed |  |  |
| UI 06 LIS warning overridden in error or outside SOP |  |  |
| UI 07 Computer issue not completed |  |  |
| UI 08 Issued visibly defective product (e.g., clots/aggregates/particulate matter) |  |  |
| UI 09 Not/incorrect checking of unit and/or patient information |  |  |
| UI 10 Product transport issues (e.g., delayed) by transfusion service |  |  |
| UI 11 Unit delivered to incorrect location by transfusion service |  |  |
| UI 12 Product transport issue (from transfusion service to clinical area) |  |  |
| UI 18 Wrong product issued for intended patient (e.g., incompatible) |  |  |
| UI 19 Inappropriate product issued for patient (e.g., not irradiated, CMV+) |  |  |
| UI 20 Confirmatory check incorrect/not performed (at time work performed) |  |  |
| UI 21 Administrative check incorrect/not performed (record review/audit) |  |  |
| UI 22 Issue approval not obtained/documented |  |  |
| UI 23 Receipt verification not performed (pneumatic tube issue) |  |  |

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| **CS: Satellite Storage**(Clinical Service)Events that occur while product is stored and handled by the clinical service. | CS 00 Detail not specified |  |  |
| CS 01 Incorrect storage conditions of product in clinical area |  |  |
| CS 02 Incorrect storage location in the clinical area |  |  |
| CS 03 Labeling issue (by clinical staff) |  |  |
| CS 04 Floor/clinic did not check for existing products in their area |  |  |
| CS 05 Product transport issues (to or between clinical areas) |  |  |
| CS 06 Monitoring of satellite storage incorrect/incomplete/not performed |  |  |
| CS 07 Storage tracking/documentation incorrect/incomplete/not performed |  |  |
| **UT: Product Administration**(Clinical Service)Events that occur during the administration of blood products. | UT 00 Detail not specified |   |  |
| UT 01 Administered intended product to wrong patient |  |  |
| UT 02 Administered wrong product to intended patient |  |  |
| UT 03 Transfusion not performed in error |  |  |
| UT 05 Bedside check (patient ID confirmation) incomplete/not performed |  |  |
| UT 06 Transfused product with incompatible IV fluid |  |  |
| UT 07 Transfusion delayed beyond pre-approved timeframe |  |  |
| UT 09 Transfused unsuitable product (e.g., outdated/inappropriately stored) |  |  |
| UT 10 Administered components in wrong order |   |  |
| UT 11 Appropriate monitoring of patient not performed |  |  |
| UT 14 Transfusion volume too low (per order or SOP) |  |  |
| UT 15 Transfusion volume too high (per order or SOP) |  |  |
| UT 16 Transfusion rate too slow (per order or SOP) |  |  |
| UT 17 Transfusion rate too fast (per order or SOP) |  |  |
| UT 18 Inappropriate preparation of product |  |  |
| UT 19 Transfusion protocol not followed (not otherwise specified) |  |  |
| UT 22 Order/consent check incorrect/not performed  |  |  |
| UT 23 Transfusion documentation incorrect/incomplete/not performed |  |  |
| UT 24 Transfusion documentation not returned to transfusion service |  |  |
| UT 26 Transfusion **reaction** protocol not followed |  |  |
| **MS: Other** | MS 99 Other |  |  |
|  | **Total** |  |  |