## Hemovigilance Module



## **Blood Product Incidents Reporting - Summary data**

Facility ID#: Month _	/ Year
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All reporting is facility-wide. Include numbers of individual reports in the totals.

*Process Point	t	*Total	*# of Adverse
		Number of	Transfusion Reactions
		Incidents	Associated w/ Incident
PC - Product Check-In (Products received from outside source)	PC 00 Detail not specified		
	PC 01 Data entry incomplete/not performed/incorrect		
	PC 02 Shipment incomplete/incorrect		
	PC 03 Product & paperwork do not match		
	PC 04 Shipped under inappropriate conditions		
30dicc)	PC 05 Inappropriate return to inventory		
	PC 06 Product confirmation		
	PC 07 Administrative check (2 <sup>nd</sup> check)		
PR -	PR 00 Detail not specified		
Product/Test	PR 01 Order for wrong patient		
Request	PR 02 Order incorrectly entered on-line		
(Clinical Service)	+PR 03 Special needs not indicated on order (e.g., CMV negative, auto)		
	PR 04 Order not done/incomplete/incorrect		
	PR 05 Inappropriate/incorrect test ordered		
	PR 06 Inappropriate/incorrect blood product ordered		
SC - Sample	SC 00 Detail not specified		
Collection	+SC 01 Sample labeled with incorrect patient name		
(Service	+SC 02 Not labeled		
collecting the samples)	+SC 03 Wrong patient collected		
	SC 04 Collected in wrong tube type		
	SC 05 Sample QNS		
	SC 06 Sample hemolyzed		
	+SC 07 Label incomplete/illegible/incorrect (other than patient name)		
	SC 08 Sample collected in error		
	SC 09 Requisition arrives without samples		
	+SC 10 Wristband incorrect/not available		
	SC 11 Sample contaminated		

## (Continued)

## +Indicates high priority codes (individual incident report must be completed)

Assurance of Confidentiality: The 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, 242b, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 2 hours 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 D-74, Atlanta, GA 30333, ATTN: PRA

(0920-0666). CDC 57.302

*Process Poi	nt	*Total	*# of Adverse
TTOCCSS FUII		Number of	Transfusion Reactions
		Incidents	Associated w/ Incident
SH - Sample	SH 00 Detail not specified		
Handling (Service collecting the	SH 01 Sample arrives without requisition		
	SH 02 Requisition & sample label don't match		
	+SH 03 Patient ID incorrect/illegible on requisition		
samples)	SH 05 No phlebotomist/witness identification		
	SH 06 Sample arrives with incorrect requisition		
	SH 07 Patient information (other than ID)		
	missing/incorrect on requisition SH 10 Sample transport issues		
SR - Sample	SR 00 Detail not specified		
Receipt	SR 01 Sample processed in error		
(Transfusion	SR 02 Historical review incorrect/not done		
Service)	SR 03 Demographic review/data entry incorrect/ not		
	done		
	SR 04 Sample incorrectly accessioned (test/product)		
	SR 05 Duplicate sample sent		
ST - Sample	ST 00 Detail not specified		
Testing	ST 01 Data entry incorrect/not performed		
(Transfusion	ST 02 Appropriate sample checks not done		
Service)	+ST 03 Computer warning overridden		
	ST 05 Sample tube w/ incorrect accession label		
	+ST 07 Sample tubes mixed up		
	+ST 09 Test tubes mislabeled (wrong patient		
	name/number) ST 10 Equipment problem		
	ST 12 Patient testing not performed		
	ST 13 Incorrect testing method chosen		
	ST 14 Testing performed incorrectly		
	ST 15 Test result misinterpreted		
	ST 16 Inappropriate/expired reagents used		
	ST 17 ABO/Rh error caught on final check		
	ST 18 Current & historical ABO/Rh don't match		
	ST 19 Additional testing not performed		
	ST 20 Administrative check at time work performed		
	ST 22 Sample storage incorrect/inappropriate		
UC Dreduct	US 00 Detail not specified		
US - Product Storage	US 01 Incorrect storage of unit in transfusion service		
(Transfusion			
Service)	US 02 Expired product in stock		
,	US 03 Inappropriate monitoring of storage device		
A\/	US 04 Unit stored on incorrect ABO shelf		
AV -	AV 00 Detail not specified		
Available for Issue	AV 01 Inventory audits		
(Transfusion	AV 02 Product status not/incorrectly updated in computer		
Service)	AV 03 Supplier recall		
	AV 04 Product ordered incorrectly/not submitted		
SE - Product	SE 00 Detail not specified		
Selection	SE 01 Incorrect product/component selected		
(Transfusion	SE 02 Data entry incomplete/incorrect		
Service)	SE 03 Not checking/incorrect checking of product		

*Process Point  and/or patient information SE 05 Historical file misinterpreted/not check SE 07 Special processing needs not unders misinterpreted SE 11 Special processing not done  UM - Product Manipulation (Transfusion Service)  UM 00 Detail not specified UM 01 Data entry incomplete/incorrect UM 02 Record review incomplete/incorrect UM 03 Wrong component selected UM 04 Administrative check (at time of manipulation) UM 05 Labeling incorrect +UM 07 Special processing needs not check +UM 08 Special processing misunderstood misinterpreted	cked cstood or c
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(Transfusion Service)  UM 02 Record review incomplete/incorrect  UM 03 Wrong component selected  UM 04 Administrative check (at time of manipulation)  UM 05 Labeling incorrect  +UM 07 Special processing needs not chech the component selected  UM 08 Special processing misunderstood misinterpreted	cked
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+UM 09 Special processing not done/incorr done	recuy
RP - Request RP 00 Detail not specified	
for Pick-up  RP 01 Request for pick-up on wrong patien	nt ent
(Clinical RP 02 Incorrect product requested for pick-	-up
Service) RP 03 Product requested prior to obtaining	consent
RP 04 Product requested for pick-up pt not	t available
RP 05 Product requested for pick-up IV not	t ready
RP 06 Request for pick-up incomplete	
RP 10 Product transport issues	
UI - Product UI 00 Detail not specified	
UI 01 Data entry incomplete/incorrect	
(Transfusion Service)  UI 02 Record review incomplete/incorrect	
Of 03 Pick-up slip aid not match patient inic	
UI 04 Incorrect unit selected (wrong person	n or right
person wrong order) UI 05 Issue delayed	
+UI 06 LIS warning overridden	
UI 07 Computer issue not completed	
UI 09 Not checking/incorrect checking of ur	nit and/or
patient information	
UI 11 Unit delivered to incorrect location	
UI 19 Wrong product issued	
UI 20 Administrative review (self, 2 <sup>nd</sup> check	´
UI 22 Issue approval not obtained/documer	nied
UT - Product Administra- UT 00 Detail not specified +UT 01 Administered product to wrong pati	iont
+UT 01 Administered product to wrong pati +UT 02 Administered wrong product to pati	
(Clinical UT 03 Product not administered	3016
Service) UT 04 Incorrect storage of product on floor	
UT 05 Administrative review (unit/patient at	
UT 06 Administrative review (uninipatient at	·
UT 07 Administration delayed	
UT 08 Wrong unit chosen from satellite refr	rigerator
UT 10 Administered components in inappro	
order order	-p

*Process Poi	nt	*Total Number of Incidents	*# of Adverse Transfusion Reactions Associated w/ Incident
	UT 11 Appropriate monitoring of patient not done		
	UT 12 Floor/clinic did not check for existing products in their area		
	UT 13 Labeling problem on unit		
	UT 19 Transfusion protocol not followed		
Other	MS 99		
TOTAL Monthly Reports			