**Hemovigilance Module**

**Monthly Incident Summary**

**\*Required for saving**

|  |  |  |
| --- | --- | --- |
| \*Facility ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \*Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***All reporting is facility-wide. Include numbers of individual incident reports in the totals.*** |
|  |
| **\*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| IM 05 Outdated product in available inventory |  |  |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 |  |  |
| **\*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 |  |  |
|  |
| **\*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) |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **\*Process Code** | **\*Incident Code** | **\*Total****Incidents** | **\*Total Adverse Reactions** |
| **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** |  |  |