

Hemovigilance Module Incident

***Required for saving**

*Facility ID#: _____	NHSN Incident #: _____	Local Incident # or Log #: _____
Discovery		
*Date of discovery: ____ / ____ / ____		
*Time of discovery: ____ : ____ (HH:MM) <input type="checkbox"/> Time approximate <input type="checkbox"/> Time unknown		
*Where in the facility was the incident discovered? _____		
*At what point in the process was the incident first discovered ? (check one)		
<input type="checkbox"/> Product check-in	<input type="checkbox"/> Order entry	<input type="checkbox"/> Sample testing
<input type="checkbox"/> Product storage	<input type="checkbox"/> Sample collection	<input type="checkbox"/> Satellite storage
<input type="checkbox"/> Inventory management	<input type="checkbox"/> Sample handling	<input type="checkbox"/> Product administration
<input type="checkbox"/> Product/test request	<input type="checkbox"/> Sample receipt	<input type="checkbox"/> Request for pick-up
	<input type="checkbox"/> Product issue	<input type="checkbox"/> Post-transfusion review/audit
		<input type="checkbox"/> Other _____
*How was the incident first discovered ? (check one)		
<input type="checkbox"/> Visual inventory review	<input type="checkbox"/> Observation by staff of unit/reagent/sample/equipment	
<input type="checkbox"/> Routine audit or supervisory review	<input type="checkbox"/> Comparison of product label to patient information	
<input type="checkbox"/> Computer system alarm or warning	<input type="checkbox"/> Comparison of product label to physician order	
<input type="checkbox"/> Comparison of sample to paperwork	<input type="checkbox"/> When checking patient ID band	
<input type="checkbox"/> Repeat or sample re-testing	<input type="checkbox"/> Notification or complaint from floor (nurse, MD, etc.)	
<input type="checkbox"/> Historical record/previous type check	<input type="checkbox"/> When product/units returned to lab	
<input type="checkbox"/> Communication from lab to floor	<input type="checkbox"/> Patient transfusion reaction	
<input type="checkbox"/> Human 'lucky catch'	<input type="checkbox"/> Other (specify) _____	
Occurrence		
*Date initial incident occurred: ____ / ____ / ____		
*Time initial incident occurred: ____ : ____ (HH:MM) <input type="checkbox"/> Time approximate <input type="checkbox"/> Time unknown		
Incident summary: (500 characters max)		

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)). CDC 57.305, Rev. 7, v9.2

Public reporting burden of this collection of information is estimated to average 10 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).

*Incident code(s): (max 20) *Use NHSN incident codes in the surveillance protocol.*

Incident Code	Occurrence Location	Incident Code	Occurrence Location
1	_____	11	_____
2	_____	12	_____
3	_____	13	_____
4	_____	14	_____
5	_____	15	_____
6	_____	16	_____
7	_____	17	_____
8	_____	18	_____
9	_____	19	_____
10	_____	20	_____

☐ MS 99 Miscellaneous, specify _____

Job function of the worker(s) involved in the incident: (max 6) *Use NHSN occupation codes in the protocol.*

☐ Other Other (OTH), specify _____ ☐ Worker unknown

*Incident result: (check one)

- ☐ 1 – Product transfused, reaction
 ☐ 3 – No product transfused, unplanned recovery
☐ 2 – Product transfused, no reaction
 ☐ 4 – No product transfused, planned recovery

*Product action: (check all that apply)

☐ Not applicable
☐ Product retrieved and returned to inventory
☐ Product retrieved and destroyed
 ^Single or multiple units destroyed?
☐ Single unit:
 Code system used: ☐ ISBT-128 ☐ Codabar
 Unit #: _____
 OR Component code: _____
☐ Multiple units: (select code system used)

<input type="checkbox"/> ISBT-128	<input type="checkbox"/> Codabar	Component code: _____	Number of units: _____
<input type="checkbox"/> ISBT-128	<input type="checkbox"/> Codabar	Component code: _____	Number of units: _____
<input type="checkbox"/> ISBT-128	<input type="checkbox"/> Codabar	Component code: _____	Number of units: _____

☐ Product issued but not transfused
☐ Product transfused
 ^Was a patient reaction associated with this incident? ☐ Yes ☐ No
 ^Patient ID#(s): _____

***Record/other action: (check all that apply)**

- ☐ Record corrected
 ☐ Floor/clinic notified
 ☐ Attending physician notified
☐ Additional testing
 ☐ Patient sample re-collected
 ☐ Other (specify) _____

Investigation Results

*Did this incident receive root cause analysis? ☐ Yes ☐ No

Custom Fields

Label

_____ / _____ / _____

Label

_____ / _____ / _____

Comments (2000 characters max)

_____ _____ _____
