

Code	Category	Definition
<i>Latent Errors</i>		Errors that result from underlying system failures
TECHNICAL		Refers to physical items such as equipment, physical installations, software, materials, labels and forms.
TEX	External	Technical failures beyond the control and responsibility of the investigating organization.
TD	Design	Inadequate design by of equipment, software or materials. Can include the design of workspace, software packages, blood drive set-up, forms and label design.
TC	Construction	Correct designs that were not constructed properly. Examples include incorrect set-up of blood drives and installation of equipment in an inaccessible area.
TM	Materials	Material defects found. Examples could be the weld seams on blood bags, defects in label adhesive, or ink smears on pre-printed labels or forms.
ORGANIZATIONAL		
OEX	External	Organizational failures beyond the control and responsibility of the investigating organization. For blood centers, this could apply to hospital. For transfusion services, this could apply to blood centers or other departments within the hospital.
OP	Protocols/Procedures	The quality and availability of the protocols with the blood center or transfusion service are too complicated, inaccurate, unrealistic, absent, or poorly presented.
OK	Transfer of Knowledge	Failures resulting from inadequate measures taken to ensure that situational or site-specific knowledge or information is transferred to all new or inexperienced staff.
OM	Management Priorities	Internal management decisions in which safety is relegated to an inferior position when faced with conflicting demands or objectives. This is a conflict between production needs and safety. An example of this is decisions made about staffing levels.
OC	Culture	A collective approach and its attendant modes to safety and risk rather than the behavior of just one individual. Groups might establish their own modes of function as opposed to following prescribed methods. An example of this is not paging a manager on the weekend because that was not how the department operated; “it’s just not done”.

Active Errors (Human)		Errors or failures that are resulting from human behavior.
HEX	External	Human failures originating beyond the control and responsibility of the investigation organization. For a blood center, this could apply to actions by individuals in hospitals. For a transfusion service, this could apply to failures by individuals from another department such as the emergency room.
Knowledge Based Behavior		
HKK	Knowledge Based Errors	The inability of an individual to apply their existing knowledge to a novel situation. An example is a trained technologist unable to solve a very complex antibody identification problem.
Rule Based Behavior		
HRQ	Qualifications	A mismatch between an individual's qualification, training or education and a particular task. An example would be expecting a technician to solve the same type of difficult problems as a technologist.
HRC	Coordination	A lack of task coordination within a health care team in an organization. An example would be an essential task not being performed because everyone thought that someone else had completed the task.
HRV	Verification	The correct and complete assessment of a situation including related conditions of the patient/donor and materials to be used before beginning the task. An example would be failure to correctly identify a patient by checking the wristband.
HRI	Intervention	Failures that result from faulty task planning and execution. This would be selecting the wrong rule or procedure (planning) or executing the procedure incorrectly. An example would be washing red cells by the same protocol as platelets.
HRM	Monitoring	Monitoring of process or patient status. An example could be a trained technologist operating an automated instrument and not realizing that a pipette that dispenses reagents is clogged.
Skill Based Behavior		
HSS	Slip	Failures in the performance of highly developed skills. An example could be a technologist adding drops of reagent to a row of test tubes and then missing a tube or computer entry error.
HST	Tripping	Failures in whole body movement. These errors are often referred to as 'slipping, tripping, or falling'. Examples can include dropping a blood bag and tripping over a loose tile on the floor.
Other Factors		
PRF	Patient-related Factors	Failures related to patient/donor characteristics or actions, which are beyond the control of the health professional team and influence treatment. An example would be a patient who deliberately uses another patient's identity card in seeking treatment.
X	Unclassifiable	Failures that can not be classified in any of the current categories.