Confidential Information

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Improving Patient Safety

Safety Situation Details

Situation ID [redacted] **Reported 04/21/2018**

The goal of the Improving Patient Safety system is to collect information about safety related incidents occurring system-wide, in order to increase organ utilization and decrease the morbidity and mortality of transplant patients.

What is a Safety Situation?
A situation or activity that affected or could have affected patient safety.

What to report:

- Any patient safety situation
- Any other situation that causes a safety concern from a transplantation, donation, and/or quality perspective.

Please report such situations in a timely manner.

Situation Information

Reporting Institution: * **CORS-Donor Alliance-Independent OPO(Member)**

Type of Safety Event (Choose all categories and subcategories that are applicable): *

- [x] Communication
  - [x] Hand off Error
  - [ ] Miscommunication of donor test results
  - [ ] Miscommunication of recipient/candidate results
  - [ ] Change in test results not reported
  - [ ] Misinterpretation of test results
  - [x] Delayed communication
  - [ ] Reliance on electronic instead of verbal communication
  - [ ] Inaccurate/insufficient donor or (organ/extra vessels) information
  - [ ] Inaccurate/insufficient candidate/recipient information
  - [ ] Missing documentation
  - [ ] Increased risk (or high risk) status of donor
  - [ ] Patient not informed adequately (or not informed at all)
  - [ ] Other (please describe in the description field below)
- [ ] Data Entry
- [x] Transportation
  - [ ] Airline (commercial)
  - [ ] Airline (charter/private)
  - [x] Ground
    - [ ] Weather
    - [ ] Traffic
    - [ ] Courier/driver
    - [x] Other (please describe in the description field below)
  - [x] Other (please describe in the description field below)

- [ ] Packaging/Shipping
- [ ] Labeling
- [ ] Recovery Procedure/Process
- [ ] Transplant Procedure/Process
- [ ] Testing
- [ ] Organ Allocation/Placement
- [ ] Other (please describe in description field below)

The Issue reported involves the following (choose all categories that are applicable): ✳

- [ ] **Recipient/Candidate**
- [x] **Donor Organ/Extra Vessels**

Donor ID associated with the event: ✳ [redacted]

Did this event involve the entire donor or were only specific organs involved? ✳ Specific Organs

Organ Type

- [x] **Right Kidney**
- [ ] **Left Kidney**
- [ ] **Double/En-bloc Kidney**
- [ ] **Pancreas**
- [ ] **Pancreas Segment 1**
- [ ] **Pancreas Segment 2**
- [ ] **Liver**
- [ ] **Liver Segment 1**
- [ ] **Liver Segment 2**
- [ ] **Intestine**
- [ ] **Intestine Segment 1**
- [ ] **Intestine Segment 2**
- [ ] **Heart**
- [ ] **Right Lung**
- [ ] **Left Lung**
- [ ] **Double/En-bloc Lung**
- [ ] **Extra Vessel(s)**

Did this safety situation cause or contribute to:

The non-recovery of organ(s)? ✳ No

The discard of any organ(s)? ✳ Yes

A delay (prolonged ischemic time) for any organ(s) transplanted? ✳ Yes

- [x] **Other (please describe in the description field below)**

Date Event Occurred: ✳ 03/20/2018

Detailed Description of the Event: ✳ A kidney for transplant was left at the Donor Alliance Recovery Center by Sterling Courier. According to their paperwork, they were to only pick up the left kidney. There was a data entry error by Sterling Courier that led to the right kidney not being added to the job with the left kidney. There was additional miscommunication between UNOS and NYRT on acceptance of the right kidney and arranging transport of the right kidney. Donor Alliance was never made aware that the right kidney was not picked up with the left kidney. DA was also not notified when alternate arrangements were supposed to be made by UNOS for right kidney to NYRT. UNOS did not have proper handoff between

shifts and to DA. The consequence of the errors in communication is that a transplantable organ had to be discarded and a recipient who was expecting to receive that kidney was not going to get a transplant.

Has a root cause analysis (RCA) been completed? * (●) Yes ( ) No ( ) In Progress

Please specify additional details regarding the RCA:

RCA by Sterling found: The data the Customer Service Representative entered into QuickTrak (Sterling's internal shipment tracking system) did not save to the job, as the Customer Service Representative neglected to hit the correct key upon exiting. The action eliminated any awareness of the additional organ to the Customer Service Representatives who were involved as the shipment progressed. RCA by UNOS found: Lack of clear or complete communication during hand off from one shift to the next. CA measures include: 1. We have reviewed and discussed this case in detail at yesterday's staff meeting to re-educate on our processes, and discuss best practices with clear and proactive communications. 2. We have decided to pilot a process of putting active transportation cases on our electronic "Active Cases" dashboard to eliminate gaps when staff change shifts. RCA by Donor Alliance found: DA organ staff needs to communicate with the tissue staff when an organ is to be picked up by a courier company. CA is to implement a communication process (white board and log for communication between organ and tissue teams).

Please upload any relevant attachments:

Contact Information

Who at your institution should UNOS contact about this case?

First Name: * [redacted] **Last Name:** * [redacted]

Phone contact (Enter at least one): *

Office: [redacted] ext. **Pager/beeper:** ext.

Mobile: [redacted] ext. **Other:** ext.

Email: * [redacted]

Other contact info:

UNOS Only

Reported by: [redacted]

Initial UNOS Action

Date: * 04/21/2018 **Staff member:** [redacted]

Status: * In process **Urgency:** * Low

Category: * Critical

Potential policy violation: ( ) YES ( ) NO

Committee notification? ( ) YES ( ) NO

Type of Safety Event (Choose all categories and subcategories that are applicable):

- [ ] Communication
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- [ ] Transportation
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- [ ] Transplant Procedure/Process
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- [ ] Organ Allocation/Placement

☐ Other (please describe in description field below)

Attachments

Correspondence/Comments

Comment	Date	User

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