Confidential Information

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Improving Patient Safety

Safety Situation Details

Situation ID [redacted] **Reported 06/12/2020**

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: * **INOP-Indiana Donor Network-Independent OPO(Member)**

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

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

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

- [ ] **Recipient/Candidate**
- [ ] **Donor Organ/Extra Vessels**
- [x] **Other (please describe in the description field below)**

Date Event Occurred: * 06/12/2020

Detailed Description of the Event: * UNOS ID [redacted] Upon recovery of the liver and bilateral kidneys, ORC 1 was completing liver anatomy with ORC 2 while ORC 3 was organizing TransNet in the hallway and getting ice for shipping box. The liver came out in the hallway with ORC 1 and 2 and ORC 3 had the shipping box set up for it so ORC 1 placed in on the ice and he returned to the OR to finish kidney anatomy with ORC 2. ORCs were still waiting for vessels to officially package the liver. ORC 3 stepped into the OR for a few minutes to obtain nodes/spleen and observed the CST (donor hospital employee) assisting the surgeon with liver flush/packaging. The kidneys were still being recovered at this point by the other two people scrubbed in. ORC 3 returned to the hall to continue charting. The MNMC team emerged from the OR and the one woman began asking if ORC 3 could escort her to the locker room so she could change out of her bloody scrubs. ORC 3 walked back to the OR and ORC 1 was packaging the liver for transport. He vocalized that the liver and vessels were going directly on ice while the biopsy was going on top of the bag. ORC 3 watched and responded that it looked good. ORC 3 also made sure documentation made its way into the box before it was closed. Meanwhile, ORC 3 was trying to get the liver surgeon to sign the operative report before leaving and finding an

OR staff member to escort them out. Upon them leaving the hall, ORC 3 realized she hadn't had any kidneys brought out to from them so she vocalized to the teammates that we will need to package kidneys and that she had the rigid containers ready with ice in them. ORC 1 began to scrub and show ORC 2 how to do so as she has not seen it before. While he was doing this, ORC 3 was transmitting kidney anatomy to DonorNet. ORC 1 asked ORC2 if she could make sure the OR team was keeping the kidney tables sterile as he noticed they were aggressively cleaning up. The patient was closed by the liver surgeon so ORC 3 figured they were beginning to un-drape her and get her ready for the morgue but leaving the tables alone. Upon checking with the OR staff, ORC 2 reported that the kidneys were not in the room. ORCs 1 and 3 began looking around to see if they were placed in the cooler by the liver team by mistake but made their way to the room where the CST was frantically pulling garbage out of the trash bin. RN began to help look through garbage at this time and it was discovered that the CST had inadvertently discarded both kidneys while tearing down sterile draping in the OR. The kidneys were recovered from the garbage bin and were noted to still be inside the three bags submerged in Servator H. ORC 3 contacted AOC who informed organ manager , organ director, and CMO. It was decided that we should call [redacted], a kidney transplant surgeon from INIM. Upon informing [redacted] of situation, he advised that we cannot confirm whether or not the kidneys maintained sterility while in the trash since the bags were not closed or tied. INOP offered the kidneys for research, but they were unable to be used for transplant.

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

Please specify additional details regarding the RCA: An immediate debrief and RCA was performed on 6/12/20. It was identified that the incident occurred because hospital personnel were not familiar with the donation process and assumed the kidneys were left on the back table to be discarded.

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: ✳ **ext.** **Pager/beeper:** **ext.**

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

Email: ✳ [redacted]@indonornetwork.org

Other contact info:

UNOS Only

Reported by: [redacted]

Initial UNOS Action

Date: ✳ 06/12/2020 **Staff member:** [redacted]

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

Category: ✳ Critical

Potential policy violation: ( ) **YES** ( ) **NO**

Committee notification? ( ) **YES** ( ) **NO**

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Attachments

Correspondence/Comments

Comment	Date	User

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